

Tracy & Keim Chiropractic, LLC  
1000 River Road  
Eugene, OR 97404  
Phone 689-0935  
Sharell Tracy, DC

**Personal Information – Please Print**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
SS# \_\_\_\_\_ E-Mail \_\_\_\_\_ Marital Status ( )M ( )S ( )D ( )W ( )P  
Referred by \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Employer \_\_\_\_\_  
Nearest relative **not** living with you \_\_\_\_\_  
Address & Phone # \_\_\_\_\_  
Nearest friend **not** living with you \_\_\_\_\_  
Address & Phone # \_\_\_\_\_

**Insurance Information**

( ) Private Insurance ( ) Personal Cash ( ) Work related accident- date of injury \_\_\_\_\_  
( ) Medicare ( ) Home Accident ( ) Other  
( ) Auto Accident- date of accident \_\_\_\_\_ Attorney \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_  
Insured's Name \_\_\_\_\_ ID #'s \_\_\_\_\_  
Have you met your deductible? ( ) Yes ( ) No

I understand that insurance policies are an arrangement between an insurance carrier and myself. This chiropractic office will assist in making collection from the insurance carrier, however, I understand that I am responsible for payment in full of all services rendered to me.

By signing this form, I am authorizing the release of copies of information kept in my file, which may be necessary to process claims. I am authorizing payment of medical benefits to be made directly to Tracy & Keim Chiropractic.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Legal Guardian signature \_\_\_\_\_

In your own words, please state the problem that caused you to seek care in our office:

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Have you had this problem before? ( ) Yes ( ) No

What have you done for treatment?

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Please summarize what other health conditions you are experiencing now, or have had in the past:

<b>Problem</b>	<b>Date problem started</b>
_____ Headaches	_____
_____ Neck pain	_____
_____ Left arm pain	_____
_____ Right arm pain	_____
_____ Mid- back pain	_____
_____ Lower back pain	_____
_____ Left leg pain	_____
_____ Right leg pain	_____
_____ Hip pain	_____
_____ Other	_____

Have you been treated by a chiropractor? ( ) Yes ( ) No

If yes, Name \_\_\_\_\_ Address \_\_\_\_\_

Name & Address of your medical doctor \_\_\_\_\_

**Please list all surgical operations**

Date	Name of surgery	Spinal level of surgery	Hospital	Doctor
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**Please list all injuries** (Severe sprains, fractures, dislocations)

Type of injury	Date of Treatment	Remaining symptoms
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**Please list all medications you are presently taking**

Medications	How often	For what purpose
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Do you have any metal implants? ( ) Yes ( ) No Where? \_\_\_\_\_

Do you have high blood pressure? ( ) Yes ( ) No Tobacco use? ( ) Yes ( ) No

Are you currently pregnant? ( ) Yes ( ) No

Height \_\_\_\_\_ Weight \_\_\_\_\_