Dr. Sandra A. Licata
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DR SANDRA A LICATA

Confidential Patient Information

Date _____

Name _____ Social Security # _____Birth date _____ Age _____

Address _____ City _____ Zip Code_____

Home Phone _____ Cell # _____ E-Mail Address_____

Marital Status M S W D # of Children_____ Primary Physician _____Phone_____

Employer _____ Occupation_____

Address_____Office Phone_____

Insurance _____Insured's Name_____Birthdate_____

Name of Wife or Husband _____Occupation _____

Employer _____Address _____

Patient's nearest relative _____Address _____ Phone_____

Is condition due to Employment or Motor Vehicle Accident? _____Was a report Filed?_____

Date symptoms Appeared or accident happened _____

Patient ever had same or similar condition: Yes ☐ No☐ if yes, when and describe _____

_____

Have you lost any days from work? _____

Date of last physical examination: _____ Female: Are you Pregnant?_____

Have you ever been under Chiropractic Care? Yes☐ No☐ Doctors Name_____

Tingling or numbness in
☐Shoulders ☐Arms ☐Elbows☐Hands
☐Hips ☐Legs ☐Knees ☐Feet

Are you currently using:
Nutritional supplements ☐Yes ☐No
Heel lifts or arch supports ☐Yes ☐No

Habits	Heavy	Moderate	Light	None
Alcohol	_____	_____	____	____
Coffee	_____	_____	____	____
Tobacco	_____	_____	____	____
Drugs	_____	_____	____	____
Exercise	_____	_____	____	____
Pop	_____	_____	____	____
Tea	_____	_____	____	____
Sweets	____	_____	____	____

Please Print
Purpose of this Appointment (Major Complaint) _____

_____

What activities aggravate your condition? _____

Is this condition getting progressively worse ? ☐Yes ☐No ☐Constant ☐Comes and goes

Is this condition interfering with your ☐Work ☐Sleep ☐Daily Routine ☐Other

When did you first notice this problem? _____

What makes your pain worse?_____
What makes your pain better? _____

Other Doctors seen for this condition? _____

Have you been treated for any health conditions by a physician in the last year? ☐Yes ☐No If Yes, please describe ____

Rate your Pain from 0-10 with a 10 being the worst pain ever

_____

Is your pain sharp dull or radiating? Other?_____

What medications or drugs are you taking? _____

Date of last X-ray _____

Past History

Have you ever been in a motor vehicle accident? ☐Yes ☐No If Yes, please describe _____

_____

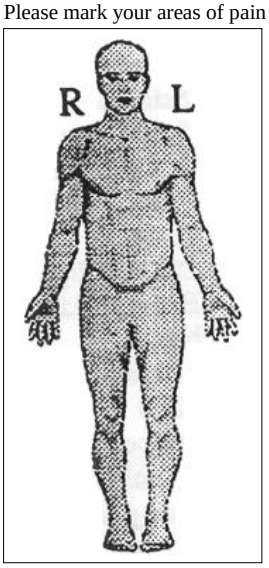
Have you suffered any fractures? ☐Yes ☐No If Yes, please describe _____

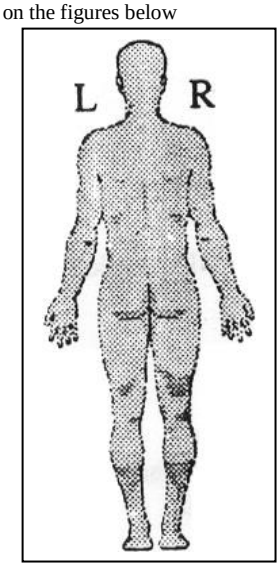
_____

What operations have you had? _____

Serious Illness _____

Please mark your areas of pain on the figures below





Family History
Please check if any of your immediate family has
Suffered from and indicate who.
☐Heart Disease _____
☐Arthritis _____
☐Cancer _____
☐Psychological Disorders _____
☐Serious Illness _____

Referred by _____

Payment is expected at time of visit.

Name of person responsible for payment _____

Are you insured? ☐Yes ☐No Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____