Allied Chiropractic
254-751-1606

200 W. Hwy 6, Suite 607
Waco, TX 76712

Patient Introduction Data

Date: ___________________

Patient Name: _______________________________ Date of Birth: _______________ Age: ______
Home Address: ___________________________ City: _____________ State: _____ Zip:________
Social Security number:______________________ E-mail Address: _________________________
Home Phone: ___________________ Cell Phone: _______________________
○ Married ○ Single ○ Other:________________ Children: ○ Yes ○ No If yes, how many? ____
Occupation: ___________________ Employer: ________________ Work Phone: ______________

Spouse Information

Spouse Name: ___________________ Cell:____________ E-mail Address:___________________
Occupation: __________________ Employer: ________________ Work Phone: _______________
Work Address: _________________________City: ___________ State: _____ Zip: ___________

Who (or what source) referred you to us? ____
Nearest relative not living with you ____
Who is responsible for payment? ○ Self ○ Spouse ○ Other _________________________________
Insurance Company: ________________________ Policy Holder: ___________________________
Insurance Policy #: _________________________ Group #: __________________________________

General Information

Primary Care Physician: _______________________Preferred Language: ____________________

Race (Circle one)
- American Indian
- Asian
- Black or African American
- Other Pacific Islander
- Alaska Native
- White
- Native Hawaiian
- Decline to State

Ethnicity (Circle one) Hispanic or Latino Not Hispanic or Latino Decline to State

Smoking Status (Circle one)
- Current Every Day Smoker
- Current Some Day Smoker
- Former Smoker
- Never Smoker

Smoking Start Date: ___________
Smoking End Date: ___________

In an effort to quit smoking, I am currently taking:__________________________

Condition Information

Purpose of this appointment (List complaints):
1) ______________________ 2) _______________________ 3) ____________________________
Date of Injury: _________________ Location: (work, home, vacation, gym, etc.) ______________
How did accident occur? ○ Auto*○ On the Job* ○ Other: __________________________________
Previous Chiropractic Care? ○ Yes ○ No If Yes, Doctor's name: ___________________________
Have you been treated by a doctor for any other health condition in the last year? ○Yes ○No
If yes, please describe:____

Dr. Ron Linderman_______________ Dr. Micah Mordecai__________________

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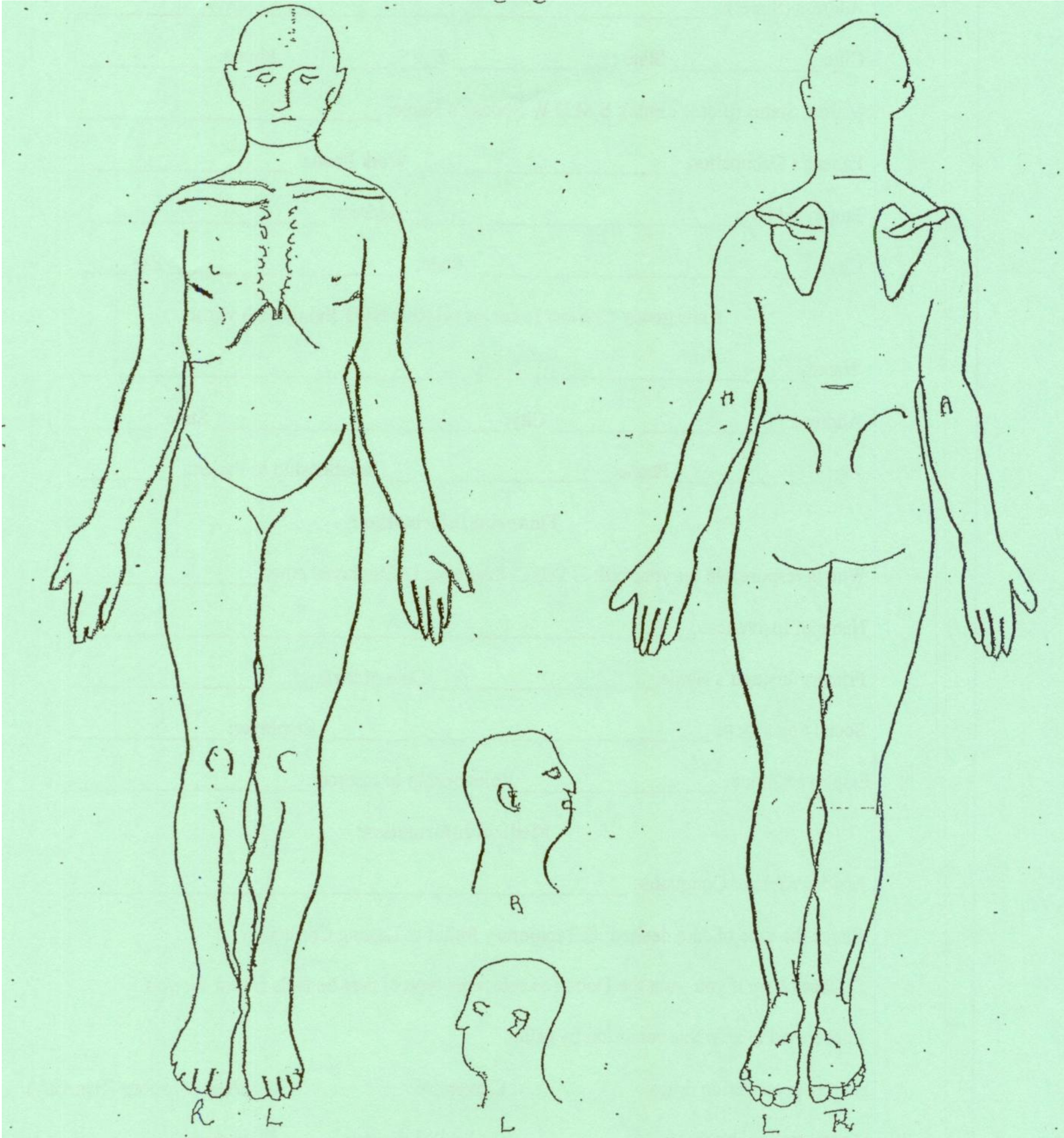
Using the following key, please indicate your areas of complaint on the picture below:

P = Pain
ST = Stiffness
N = Numbness
B = Burning
T = Tingling



I acknowledge that the information stated on this form is accurate and true to the best of my knowledge:

Signature: ___________________________________ Date: ___________________________________

Dr. Ron Linderman_______________

Dr. Micah Mordecai_________________

History

200 W. State Hwy 6, Suite 607 **Phone 254-751-1606**
Waco, TX 76712 **Fax 866-571-1622**

First Name_____________________M.I.___Last Name_________________________
Have you had spinal X-rays, MRI or CT Scan? □No
□Yes, Date(s) and place taken____

____

Please check all of the following that apply to you or check: □ **NONE APPLY**

NO	YES		NO	YES	
□	□	History of recent Infection	□	□	Recent Trauma
□	□	Recent Fever	□	□	Prostrate Problems
□	□	HIV / AIDS	□	□	Frequent Urination
□	□	Diabetes	□	□	Pregnancy, # of Births:_____
□	□	Corticosteroid Use	□	□	Abnormal Weight Gain/Loss
□	□	Surgery, Type:________	□	□	Epilepsy / Seizures
□	□	High Blood Pressure	□	□	Visual Disturbances
□	□	Stroke, Date:___________	□	□	History of low/mid back pain
□	□	Dizziness / Fainting	□	□	History of neck pain
□	□	Numbness in Groin / Buttocks	□	□	Arthritis
□	□	Urinary Retention	□	□	History of alcohol use
□	□	Aortic Aneurysm	□	□	History of tobacco use
□	□	Cancer / Tumor	□	□	Medication:Or give list for copy
□	□	Osteoporosis			

Current Medication: Medication______________________ Dosage______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Does your family have a history of any of the following?
□ Cancer □ Diabetes □ High Blood Pressure □ Cardiovascular Problems / Strokes

PAST MEDICAL HISTORY

SURGERY:____
PROLONGED HOSPITALIZATION:____

Patient Signature:____ Date:________________

Office section below Not for Patients! Thank You!

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Comments regarding History as stated above.

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____

_____________________________ _____________________________
Dr. Ronald Linderman Dr. Micah Mordecai