Lofton Chiropractic Clinic **(205) 854-3008**
Dr. Troy Lofton, D.C.
1705 Centerpoint Pkwy
Birmingham, AL 35215

DATE: _____

PATIENT DATA

FIRST NAME: _____ MI: _____ LAST NAME: _____

BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY #: _____ MARITAL STATUS: _____

SPOUSE'S NAME: _____

HOW DID YOU HEAR ABOUT US? _____

MAILING ADDRESS

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____ **YOUR EMAIL WILL NOT BE SHARED**

HOME #: _____ CELL #: _____ WORK #: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ CONTACT #: _____

CURRENT COMPLAINTS

NATURE OF INJURY: ☐ **AUTOMOBILE** ☐ **WORK** ☐ **OTHER** DATE OF INJURY: _____

HAVE YOU EVER HAD THE SAME CONDITION? ☐ NO ☐ YES IF YES, WHEN: _____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? ☐ NO ☐ YES IF YES, WHEN: _____

LIST OF OTHER PRACTITIONERS SEEN FOR THIS INJURY/CONDITION: _____

IF INJURY IS DUE TO AUTO ACCIDENT, PLEASE PROVIDE INFORMATION

THEIR INSURANCE COMPANY: _____ CONTACT PERSON: _____ PHONE #: _____

YOUR INSURANCE COMPANY: _____ CONTACT PERSON: _____ PHONE #: _____

DO YOU HAVE MED PAY?: ☐ NO ☐ YES AMOUNT: $ _____ CLAIM #: _____

ATTORNEY: _____ PHONE #: _____

SIGNATURES

NAME OF THE INSURED: _____

I UNDERSTAND AND AGREE THAT HEALTH/ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME CHARGED ARE MY PERSONAL RESPONSIBILITY FOR TIMELY PAYMENT. I UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE/TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE: _____ DATE: _____

SPOUSE'S OR GUARDIAN'S SIGNATURE: _____ DATE: _____

MEDICAL HISTORY

HAVE YOU BEEN TREATED FOR ANY CONDITIONS IN THE LAST YEAR? ☐ NO ☐ YES

IF YES, PLEASE DESCRIBE: _____

DATE OF LAST PHYSICAL EXAM: _____ IS THERE A CHANCE YOU ARE PREGNANT? ☐ NO ☐ YES

HAVE YOU HAD X-RAYS TAKEN WITHIN THE LAST 2 YEARS? ☐ NO ☐ YES IF YES, WHERE?: _____

HAVE YOU EVER:	NO	YES	BRIEFLY EXPLAIN
BROKEN BONES	☐	☐	
BEEN HOSPITALIZED	☐	☐	
BEEN IN AN AUTO ACCIDENT	☐	☐	
HAD SPRAINS / STRAINS	☐	☐	
BEEN STRUCK UNCONSCIOUS	☐	☐	
HAD SURGERY	☐	☐	
HIV / STD	☐	☐	

	NO	YES
DO YOU EXPERIENCE PAIN EVERY DAY?	☐	☐
DO YOUR SYMPTOMS INTERFERE WITH DAILY LIFE?	☐	☐
DOES PAIN WAKE YOU UP AT NIGHT?	☐	☐
ARE YOUR SYMPTOMS WORSE DURING CERTAIN TIMES OF THE DAY?	☐	☐
DO CHANGED IN WEATHER AFFECT YOUR SYMPTOMS?	☐	☐
DO YOU WEAR ORTHOTICS?	☐	☐
DO YOU TAKE VITAMIN SUPPLEMENTS?	☐	☐

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS? _____

_____

HABITS	NONE	LIGHT	MODERATE	HEAVY	HOW OFTEN / HOW MANY
ALCOHOL	☐	☐	☐	☐	
COFFEE	☐	☐	☐	☐	
SOFT DRINKS	☐	☐	☐	☐	
WATER	☐	☐	☐	☐	
EXERCISE	☐	☐	☐	☐	
TOBACCO	☐	☐	☐	☐	
DRUGS	☐	☐	☐	☐	
SLEEP	☐	☐	☐	☐	
APPETITE	☐	☐	☐	☐	
SALTY FOODS	☐	☐	☐	☐	
SUGARY FOODS	☐	☐	☐	☐	
ARTIFICIAL SWEETNERS	☐	☐	☐	☐	

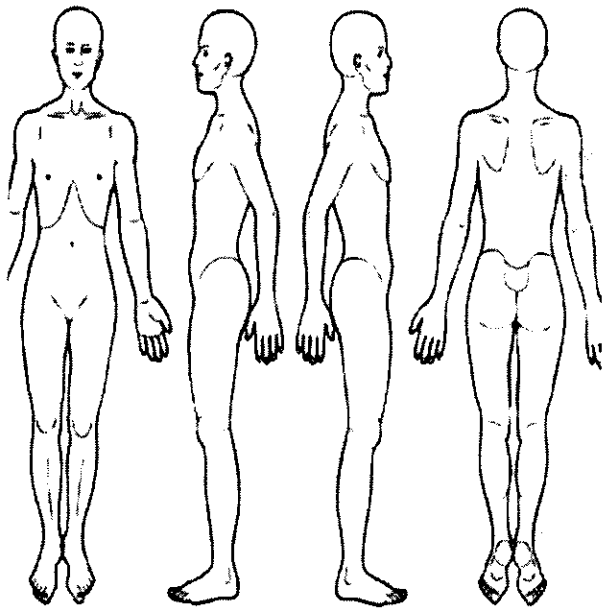
FAMILY HISTORY:	NO	YES		NO	YES
HIGH BLOOD PRESSURE?	☐	☐	KIDNEY DISEASE?	☐	☐
HIGH CHOLESTEROL?	☐	☐	LUNG DISEASE?	☐	☐
HEART ATTACK?	☐	☐	ALZHEIMER'S?	☐	☐
CANCER?	☐	☐	OSTEOPOROSIS?	☐	☐
DIABETES?	☐	☐			

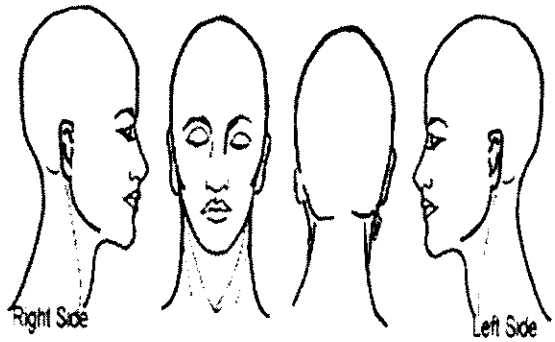
HAVE YOU EVER SUFFERED FROM:

- ☐ ALCOHOLISM
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ARTERIOSCLEROSIS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BREAST LUMP
- ☐ CANCER
- ☐ CHEST PAIN / CONDITIONS
- ☐ COLD EXTREMITIES
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EARS RINGING
- ☐ FATIGUE
- ☐ FREQUENT URINATION
- ☐ HEADACHE
- ☐ HIGH BLOOD PRESSURE
- ☐ IRREGULAR HEART BEAT
- ☐ LOSS OF MEMORY
- ☐ LOSS OF BALANCE
- ☐ NOSEBLEEDS
- ☐ PACEMAKER
- ☐ POLIO
- ☐ PROSTATE TROUBLE
- ☐ SHORTNESS OF BREATH
- ☐ STROKE
- ☐ SWELLING OF ANKLES
- ☐ THYROID CONDITION
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VARICOSE VEINS

PLEASE USE THE FOLLOWING LETTERS TO INDICATE **TYPE** AND **LOCATION** OF THE SYMPTOMS YOU CURRENTLY ARE EXPERIENCING.

A=Ache	**O**=Other
B=Burning	**P**=Pins & Needles
N=Numbness	**S**=Stabbing





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PATIENT MEDICATIONS AND ALLERGIES

PATIENT'S NAME: _____ **DATE:** _____

ARE YOU TAKING ANY MEDICATION? ☐ Yes ☐ No

*IF YES PLEASE LIST BELOW

MEDICATIONS:

DO YOU HAVE ALLERGIES? ☐ Yes ☐ No

*IF YES PLEASE LIST BELOW

DO YOU SMOKE? ☐ Yes ☐ No

If YES, how often_____