DR. DENNY DUMLER
Chiropractic Physician

ALAN GIRON, W.I.T.S., A.F.A.A.
Sports Rehabilitation & Athletic Trainer

Valley Spine

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

LAST NAME: FIRST: MIDDLE:			DATE:
ADDRESS: CITY: ST: ZIP:			
HOME PHONE: ( ) WORK PHONE: ( ) CELL PHONE: ( )			
SSN: GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH:		AGE:
MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED			
PATIENT EMPLOYER:		OCCUPATION:	
EMPLOYER ADDRESS:	CITY:	STATE:	ZIP:
IF PATIENT IS A MINOR: PARENT/GUARDIAN LAST NAME:		FIRST NAME:	

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL: LAST NAME		FIRST NAME:	
GUARANTOR ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE: ( ) WORK PHONE: ( ) CELL PHONE: ( )			
SSN: GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH:		AGE:

EMERGENCY CONTACT

LAST NAME OF LOCAL FRIEND OR RELATIVE:	FIRST NAME:	RELATIONSHIP:	
HOME PHONE: ( ) WORK PHONE: ( ) CELL PHONE: ( )			

INSURANCE INFORMATION

PRIMARY INSURANCE CO. NAME:		PHONE:	
ADDRESS TO MAIL CLAIMS:	CITY:	STATE:	ZIP:
POLICY HOLDER LAST NAME:	FIRST NAME		INITIAL:
SSN:	DATE OF BIRTH:	RELATION TO PATIENT:	
POLICY/ID# GROUP #:	EMPLOYER:	CITY:	STATE:
SECOND INSURANCE CO. NAME:		PHONE:	
ADDRESS TO MAIL CLAIMS:	CITY:	STATE:	ZIP:
POLICY HOLDER LAST NAME:	FIRST NAME:		INITIAL:
SSN:	DATE OF BIRTH:	RELATION TO PATIENT:	
POLICY/ID# GROUP #:	EMPLOYER:	CITY:	ZIP:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize VALLEY SPINE or insurance company to release any information required to process my claims.

PATIENT OR GUARDIAN SIGNATURE:	DATE:

SYMPTOMS: Reason for visit? When did you first notice the symptoms?

Is this condition getting progressively worse? Where specifically is the problem(s) located?

What activities are difficult to perform or aggravates the pain? Sitting Standing Walking Bending Lying down Other:

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain: (1, mild pain or discomfort – 10, severe pain) 1 2 3 4 5 6 7 8 9 10 | Is the pain constant or does it come and go?

What treatment have you already received for your condition? Medication Surgery Physical Therapy Other:

HEALTH HISTORY: Circle only those which are applicable.

AIDS/HIV	Blood in Stool	Diabetes	Hernia	Mononucleosis	Psychiatric Care	Tumor/Growth
Alcoholism	Blurred Vision	Emphysema	Herniated Disc	Nausea/Vomiting	Rheumatic Fever	Ulcers
Allergy Shots	Breast Lump	Epilepsy	High Blood Pressure	Osteoporosis	Scarlet Fever	Other:
Anemia	Bronchitis	Fractures	High Cholesterol	Parkinson's Disease	Shortness of Breath	
Appendicitis	Cancer	Glaucoma	Measles	Pinched Nerve	Stroke	
Arthritis	Chest Pain	Gout	Migraine Headaches	Pneumonia	Suicide Attempt	
Asthma	Chicken Pox	Heart Disease	Miscarriage	Polio	Trouble Swallowing	
Bleeding Disorder	Depression	Hepatitis	Multiple Sclerosis	Prosthesis	Tuberculosis	

Last exam of those circled: | Primary Physician:

(Women) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No

FAMILY HISTORY: Have any direct relatives had any of the above disorders? If so, which relative and which disorder?

SURGICAL HISTORY: List major surgeries and or illnesses:

1)	Date:	Doctor/State:
2)	Date:	Doctor/State:
3)	Date:	Doctor/State:

CURRENT MEDICATIONS:

1. Name:_____ Strength:_____ per day:_____ for:_____ Doctor:_____
2. Name:_____ Strength:_____ per day:_____ for:_____ Doctor:_____
3. Name:_____ Strength:_____ per day:_____ for:_____ Doctor:_____

ALLERGIES TO MEDICATIONS:

Name::_____ Reaction:_____

Name::_____ Reaction:_____

Name::_____ Reaction:_____

SOCIAL HISTORY:

Do you use tobacco? ☐ Yes ☐ No If yes, packs per day_____ per month_____

Alcohol use? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Other _____/week

Do you exercise regularly? ☐ Yes ☐ No If yes, how often?_____

Current weight: _____Pounds Height: _____ Ft. _____ In.

PLEASE SIGN: The information on these forms is accurate to the best of my knowledge.

Patient Name::_____ Date:_____

********** **FOR OFFICE USE ONLY** **********

Completed_____ Date_____ Reviewed by _____