

Alternative Health Clinic

4810 N. Kings Highway • Myrtle Beach, SC 29577 • (843) 692-9243

CONFIDENTIAL PATIENT CARD

I.D.N.S: _____

Name _____
(Ms. Mrs. Mr.) _____ Sex: M / F SS# _____ - _____ - _____

Street _____ City _____ State _____ ZIP _____

Home Phone () _____ Age: _____ Date of Birth: _____

Height _____ Weight _____ lbs. E-Mail: _____

Occupation _____ Business Phone () _____

WHERE DO YOU HURT? CHECK SYMPTOMS YOU ARE HAVING

- | | | |
|---|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Constipation - BM / Day / Week |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Arm Pain Rt or left | <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Stress | <input type="checkbox"/> Short Breath |
| <input type="checkbox"/> Clicking Jaw | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Loss / Poor Sleep | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Leg pain Rt. or left | <input type="checkbox"/> Fever | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Hip Pain Rt. or left | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ear Ache or Ringing |
| <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Other | <input type="checkbox"/> Menstrual Issues |

Referred To This Office By: _____

Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Care # _____

Have you tested HIV positive? yes no

I hereby authorize Alternative Health Clinic to examine me, including X-rays if indicated by the exam, and to release my records to anyone I designate in writing. I further authorize treatments deemed necessary by the findings and I request all my chiropractic records be held in strict confidence and not be given to anyone without my written consent. **I CLEARLY UNDERSTAND THAT I AM TOTALLY RESPONSIBLE FOR ALL CHARGES SHOULD MY INSURANCE COMPANY DENY PAYMENT.**

By signing your name below you certify the accuracy of your medical and/or accident history and further certify that you present to Alternative Health Clinic for evaluation and/or treatment of a health condition and for no other purpose.

Patient Signature: _____ Date: _____

Authorization to treat minor _____
(Parent or Guardian)