

Weis Chiropractic Health Center  
**CONFIDENTIAL PATIENT INFORMATION FORM – ROP**  
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Cincinnati, OH 45241  
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## **Instructions**

The information on this document is kept in your confidential patient file in our office as a record of your office visit. This document is to be submitted when you have visited our office during the current calendar year.

After printing the document, please fill it out completely. Bring the completed and signed document with you to your office visit. By doing so you'll be able to speed up the initial registration process of your office visit.

**Patient Details**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_  
**Marital Status:**  Married  Single  Divorced  Widowed  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Employer Name:** \_\_\_\_\_  
**Employer Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_  
**Name of Spouse (parent, if you are a minor):** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Visit Details**

**Chief Complaint:** \_\_\_\_\_  
**Date Problem Started:** \_\_\_\_\_ **Auto Accident Related:**  Yes  No **Work Related:**  Yes  No  
**Since your last visit have you required surgery or hospitalization?**  Yes  No **If yes, please explain briefly the details:** \_\_\_\_\_  
**Since your last visit have you required treatment from another physician?**  Yes  No **If yes please explain briefly the details:** \_\_\_\_\_  
**Do you suspect that you may be pregnant?**  Yes  No  
**Are you currently taking any over the counter medications?**  Yes  No **Explain:** \_\_\_\_\_  
**Are you currently taking medications for the following:** Anti-inflammatory  Muscle Relaxants  Birth Control   
Blood Thinners  High Blood Pressure  Pain Relievers   
Other  Explain: \_\_\_\_\_  
**Have you ever been diagnosed with:** High Blood Pressure  Heart Attack  Emphysema  Seizures/Convulsions   
Thyroid Disease  Circulation Problems  Cancer  (If yes, please describe type of cancer: \_\_\_\_\_  
)

Please note: payment or insurance co-payment is expected at time of visit.

Patient Signature / Date