Dr. Charles E. Copeland, DC ♦ Highland Chiropractic

Name: _____
Birth Date: ____/_____/_____ Gender M / F
Address: _____
City: _____ State: _____ Zip: _____

Occupation: _____
Employer: _____
How did you hear about us?
_____

Home Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
E-mail Address: _____

Preferred Phone to Contact
☐ Home ☐ Work ☐ Cell
Preferred Method of Contact
☐ Phone ☐ Mail ☐ Email

Race – check one

☐ American Indian / Alaska Native
☐ Asian
☐ Black / African American
☐ More than one race
☐ Native Hawaiian
☐ Pacific Islander
☐ White
☐ Unreported / Refused to Report

Ethnicity – check one

☐ Hispanic / Latino
☐ Non-Hispanic / Latino
☐ Unreported / Refused to Report

Preferred Language

☐ English
☐ German
☐ Spanish

PRESENT HEALTH PROBLEMS:
Please list your complaints in order from the most severe to the least and estimate the amount of time you have had this complaint.

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____
5. _____ How long? _____

Is condition related to an accident? ☐ No – **OR** – ☐ Auto ☐ Work related ☐ Other **Accident Date:** ___/___/___

How and when did it start? _____
What Doctors have you seen for this condition? _____
What makes it better? _____
What makes it worse? _____
Have you had surgery for this condition? ☐ Yes ☐ No If yes, when?_____
Do you have a family history related to this condition? _____

Female History: Date of last menstrual cycle _____/_____/_____ ☐ Regular ☐ Irregular
Are you pregnant at this time? ☐ Yes ☐ No

FOR OFFICE USE ONLY
Member of Doctor's Staff _____ Date: _____

INSURANCE INFORMATION:
Insurance Carrier: _____
Insured's Name: _____
Insured's Date of Birth: _____/_____/_____

Other Method of Payment: _____

I authorize payment of medical benefits to this office.

Signed: _____ Today's Date: _____
(Signature of patient or parent/legal guardian, if a minor)

1525 Bardstown Road ♦ Louisville, KY 40205 ♦ Phone: (502) 454-5000 ♦ Fax: (502) 454-5225