

Welcome

Patient Information

Date _____
SSN/HIC/Patient ID # _____
Name _____
Address _____
City _____
State _____ Zip _____
E-Mail _____
Sex: M ___ F ___ Age _____
Date of Birth _____
Married ___ Widowed ___ Single ___ Minor ___
Separated ___ Divorced ___ Partnered for ___ Years ___
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birth Date _____
Social Security # _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Phone Numbers

Phone (Home) (_____) _____
Cell Phone (_____) _____
Best time & place to reach you _____

In case of emergency contact

Name _____
Relationship _____
Home Phone (_____) _____
Work Phone (_____) _____

Patient Condition

Reason for visit _____
When did your symptoms appear? _____
Is this condition progressively getting worse? Yes ___ No ___ Unknown ___
Mark an X on the pictures where you continue to have pain, numbness, or tingling.
Type of pain: Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___
Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other ___
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with: Work? _____ Sleep? _____ Daily Routine? _____ Recreation? _____
Activities or movements that are painful to perform: Sitting ___ Standing ___ Walking ___ Bending ___ Lying Down ___

Insurance

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Company _____
Group # _____
Is patient covered by additional insurance? Yes ___ No ___
Subscriber's Name _____
Relationship to Patient _____
Birth Date _____ SS# _____
Insurance Company _____
Group # _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to

Name of Insurance Company _____

Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

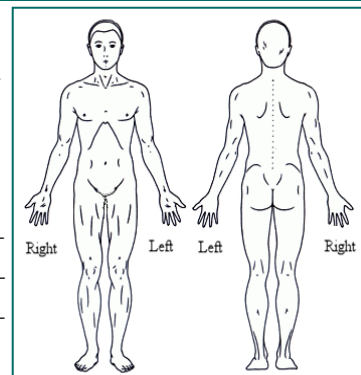
Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____

Relationship to Patient _____

Accident Information

Present condition due to an accident? ___ Yes ___ No ___
Date _____
On the Job ___ Auto Accident ___ Home ___ Other ___
Has accident been reported? Yes ___ No ___ To Employer ___
Auto Carrier ___ Worker Comp ___ Other _____
Attorney Name (if applicable) _____



HEALTH REPORT:

What treatment have you already received for your condition? Medications ___ Surgery ___ Physical Therapy ___
 Chiropractic Services ___ None ___ Other ___

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

Place a check mark next to the Yes or No to indicate if you have had any of the following:

Aids/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
		Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
				Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Exercise

None
 Moderate
 Daily
 Heavy

Work Activity

Sitting
 Standing
 Light Labor
 Heavy Labor

Habits

Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications

Pharmacy Name _____

Pharmacy Phone (____) _____

Allergies

Vitamins/Herbs/Minerals

