Patient Information

Date_____

Patient Name_____ Date of Birth _____

Address_____

City_____ State_____ Zip Code_____

Phone Number_____ Cell Phone _____

Email Address (optional) _____

Place of Employment_____ Phone Number _____

Emergency Contact_____ Phone Number _____

Whom may we thank for referring you to our office? _____

Insurance Information

Name of Policy Holder_____ Date of Birth _____

Relationship to Policy Holder _____

Name of Insurance Carrier(s)_____

Policy Number/ID Number _____Group Number_____

Customer Service Number on Insurance Card _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company) and assign directly to 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 ad their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This 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) (Date)

_____ _____

(Please Print Name of Patient, Parent, Guardian or Personal Representative) (Relationship to Patient)

Patient Condition

Presenting Complaint(s) _____

When did your symptoms appear? _____ How often do you have this pain? _____

Is condition due to an accident? □ Yes □ No Date _____ Type of accident □ Auto □ Work □ Home

Is this condition getting progressively worse? □ Yes □ No

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

(Over)

Health History

What treatment have you had already for your condition? □ Medication □ Surgery □ Physical Therapy

□ Chiropractic Service □ None □ Other _____

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

Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____ Blood Test _____

Chest X-Ray _____Urine Test _____ MRI _____ CT-Scan_____ Bone Scan _____

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

AIDS/HIV	□ Yes □ No	Liver Disease	□ Yes □ No
Alcoholism	□ Yes □ No	Measles	□ Yes □ No
Allergy Shots	□ Yes □ No	Migraine Headaches	□ Yes □ No
Anemia	□ Yes □ No	Miscarriage	□ Yes □ No
Anorexia	□ Yes □ No	Mononucleosis	□ Yes □ No
Appendicitis	□ Yes □ No	Multiple Sclerosis	□ Yes □ No
Arthritis	□ Yes □ No	Mumps	□ Yes □ No
Asthma	□ Yes □ No	Osteoporosis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Pacemaker	□ Yes □ No
Breast Lump	□ Yes □ No	Parkinson's Disease	□ Yes □ No
Bronchitis	□ Yes □ No	Pinched Nerve	□ Yes □ No
Bulimia	□ Yes □ No	Pneumonia	□ Yes □ No
Cancer	□ Yes □ No	Polio	□ Yes □ No
Cataracts	□ Yes □ No	Prostate Problems	□ Yes □ No
Chem. Dependency	□ Yes □ No	Prosthesis	□ Yes □ No
Chicken Pox	□ Yes □ No	Psychiatric Care	□ Yes □ No
Diabetes	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Emphysema	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Epilepsy	□ Yes □ No	Scarlet Fever	□ Yes □ No
Fractures	□ Yes □ No	Stroke	□ Yes □ No
Glaucoma	□ Yes □ No	Suicide Attempt	□ Yes □ No
Goiter	□ Yes □ No	Thyroid Problems	□ Yes □ No
Gonorrhea	□ Yes □ No	Tonsillitis	□ Yes □ No
Gout	□ Yes □ No	Tuberculosis	□ Yes □ No
Heart Disease	□ Yes □ No	Tumors, Growths	□ Yes □ No
Hepatitis	□ Yes □ No	Typhoid Fever	□ Yes □ No
Hernia	□ Yes □ No	Ulcers	□ Yes □ No
Herniated Disk	□ Yes □ No	Vaginal Infections	□ Yes □ No
Herpes	□ Yes □ No	Venereal Disease	□ Yes □ No
High Blood Pressure	□ Yes □ No	Whooping Cough	□ Yes □ No
High Cholesterol	□ Yes □ No	Other _____	

Are you pregnant? □ Yes □ No Due Date _____

Exercise □ None □ Moderate □ Daily □ Heavy

Work Activity □ Sitting □ Standing □ Light Labor □ Heavy Labor

Habits □ Smoking _____ Packs/Day □ Alcohol ____ Drinks/Week

□ Coffee/Caffeine ____ Drinks/Week □ High Stress Level

Injuries/Surgeries (Falls, Head Injuries, Broken Bones, Dislocations) _____

_____

Medications/Vitamins/Allergies_____