WHAT'S NEW

1 ABOUT YOU

Today's Date: ____ / ____ / ____ File #: ____

Patient Name: ____
LAST FIRST MI

Mailing Address: ____
(❑ UNCHANGED)

____
CITY STATE ZIP

Home phone: (____) ____

(____) ____ EXT. (____) ____
OFFICE PHONE CELL PHONE

E-mail Address: ____

Employer: ____
(❑ UNCHANGED)

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Marital Status: ____
(❑ UNCHANGED)

Spouse's Name: ____

2 INSURANCE INFO

Has any of your Insurance Information changed? ❑ No ❑ Yes
If your insurance info has **not** changed, please continue on to block 3.

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____ / ____ / ____

Insured's Employer: ____

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please provide any **new** Primary/Secondary Ins. cards with this form.

3 MEDICAL INFO

What Medications are you taking? (please include over-the-counter drugs) ____

____

Please list any **new** allergies, diseases, medical conditions, or procedures; include dates when possible: ____

____

____

In event of an emergency, whom should we contact? ____

Relation: ____ Phone #: (____) ____ Cell #: (____) ____

Who is your medical doctor? ____ Phone #: (____) ____

Has our office/staff met or surpassed your expectation of treatment? ❑ Yes ❑ No ❑ Somewhat

Comments: (if any) ____

____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature ____ Date: ____ / ____ / ____

five REASON FOR VISIT

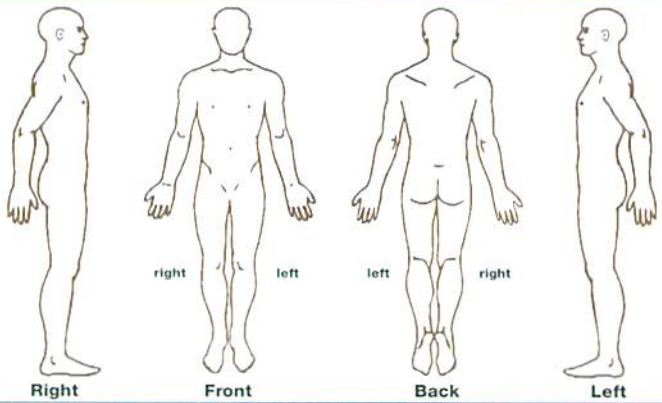
Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



six HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ___ Date ___/___/___ Comments
Initials ___ Date ___/___/___ Comments
Initials ___ Date ___/___/___ Comments

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

Additional Comments:

Patient Name _____ Patient Signature _____

Examiner _____ Date _____ Score _____ [72]