In order to help our patients obtain all insurance benefits for which they are eligible, we will need the following information completed.

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself, Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable.

Patient's Signature _____ S.S.# _____ Date _____

Other Responsible Party _____ S.S. # _____ Information taken by; _____

Motor Vehicle Crash Information

Date of the crash: _____

My crash occurred in (circle the state): MA NH ME CT NY VT CT Other: _____

Insurance Information

List the auto insurance company for the vehicle **in which YOU were riding or driving**: _____

Insured's Name : _____

Please list your claim number: _____

Other vehicle's insurance company: _____

Driver of other vehicle:_____

Insured's Name: _____

Attorney's Name: _____

Attorney's Phone Number: _____

RYAN CHIROPRACTIC
DR. MICHAEL T. RYAN III
9 NAHANT STREET
LYNN, MA 01902
781-595-6560

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably ,we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. *Thank You.*

Date _____

Name _____ Home Phone _____

Street _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital Status: S M W D How Many Children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/ Husband _____ Occupation _____

Employer _____ Office Phone _____

Other Nearest Relative _____ Phone _____

Heard about our office through _____

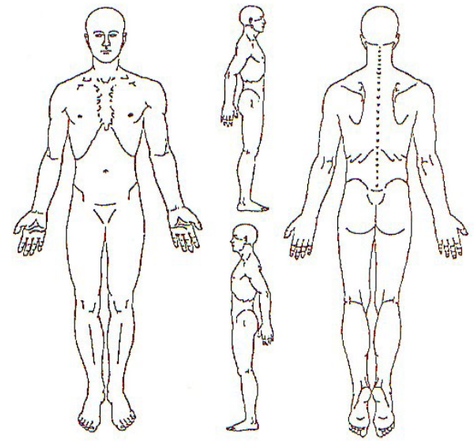
Email Address _____

List present complaints, injuries and duration:

1. _____
2. _____
3. _____

Remarks and details of any accident: _____

Please mark your areas of pain on the figures below.



List other doctors consulted for present complaints and injuries:

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see doctor? _____ How frequently? _____

Results _____

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see doctor? _____ How frequently? _____

Results _____

Present family doctor _____

Date of last physical examination _____ By Doctor _____

–Turn Page

NAME: _____

What surgeries have you had

Type/ When/Doctor/Remarks _____

_____

_____

List former serious accidents and falls: (auto, work, home, leisure, sports, other — circle one)

What/When/Symptoms/Treatment/Results _____

_____

_____

List broken bones:

What/When/Remarks _____

_____

_____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/ Remarks _____

_____

_____

Environment

Work - (Please circle appropriate answer)

Seated/Standing - Work Bench/Desk/Counter/Other _____

Job involves - Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other _____

Chair - Executive/Steno/ Bench/Stool/ Folding/ Other _____ Shoes - High heels/Boots/Other _____

Leisure

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe) _____

_____

Strenuous activities? Exercise - Type/Frequency/Length of time? _____

_____

Sports - Type/Frequency/Length of time? _____

If you have discontinued sports or strenuous activities, why the change? _____

Exert yourself - Frequently/Occasionally/Rarely/Never? Describe how? _____

_____

Are you HIV positive? ___ No ___ Yes Is there any chance that you are currently pregnant? ____ No ____ Yes

Do Not Write In This Box (For Office Use Only)

1. RP	
2. HL	
3. T/SP	
4. D/P-E	
5. D/TT-E	
6. AA/AE	
7. I N L/W	
8. HR-W-E	
9. OD/P-R-E	
10. OD/OP-R-E	
11. RDT-S	
12. D/P-OP	

NAME: _____

Circle Current Conditions — Check Former Conditions

PRIMARY SYMPTOMS

MUSCULO-SKELETAL

Recurring Headaches
Eye or sinus pain
Facial spasms
Facial/jaw pain
Restricted movement-head/neck
Neck pain
Neck spasms
Poor posture
Upper back pain
Sore, aching "shawl" muscles
Pain-shoulder/arm/hand
Painful/stiff joints
Swollen arm/hand
Restricted movement-shoulder/arm/hand
Arthritis
Bursitis
Pain beneath/under shoulder blade
Pain around collar bone
Mid back pain
Chest pain
Rib cage pain
Pain beneath/below breast bone
Hiatal hernia
Restricted movement-torso
Scoliosis
Low back pain
Rheumatism
Neuritis
Neuralgia
Lumbago
Painful tailbone
Buttock pain
Hip pain
Sciatica
Swollen/painful/stiff joints-Leg/Foot
Restricted movement -Leg/Foot
Leg cramps
Leg pain-lower/upper
Foot/Toe pain
Sore/weak muscles
Walking problems

CORRELATING SYMPTOMS

NERVOUS SYSTEM

Hot/cold spots	Nervousness	Insomnia
Numbness/tingling	Personality Change	Depression
Dizziness	Anxiety	Confusion
Fainting	Irritability	Forgetfulness
Paralysis	Tremors	Hiccups
Convulsions	Tension	

EYE, EAR, NOSE & THROAT

Visual Disturbances	Hearing Loss	Canker sores
Light Sensitivity	Ear discharge	Dental Problems
Zig Zag flashes	Nose pain	Difficulty speaking
Eye strain	Nose bleeding	Sinus trouble
Eye inflammation	Nose discharge	Hayfever/allergies
Vision problems	Difficult breathing	Sore throat
Chronic earache	Through nose	Hoarseness
Ear Noises	Sore Mouth/gums	Head colds

RESPIRATORY

Difficulty breathing	Asthma	Tuberculosis
Chronic cough	Allergies	Chest colds
Coughing phlegm/blood		

CARDIO-VASCULAR

Heart attack	Slow beating heart	Poor circulation
High blood pressure	Pain over heart	Stroke
Low blood pressure	Hardening of arteries	Varicose veins
Rapid beating heart	Swelling of ankles	

SKIN

Skin disorder	Itching	Boils
Acne	Bruise easily	Hives or allergies
Shingles	Dryness	

GENERAL

Fever	Sweats	Cancer
Thyroid disorder	Rheumatic fever	Loss of weight
Chills	Chronic fatigue	Weight trouble
Diabetes		

GASTRO-INTESTINAL

Chronic nausea	Belching gas	Diverticulosis
Vomiting	Gastritis/heartburn	Hemorrhoids
Vomiting blood	Pain over stomach	liver trouble
Food allergy	Ulcers/stomach disorder	Gall bladder trouble
Food appetite	Distention of abdomen	Jaundice
Excessive Hunger	Constipation	Black stool
Difficulty chewing/swallowing	Diarrhea	Bloody stool
Excessive thirst	Colitis	

GENITO-URINARY

Urine disorder-frequent/	Bladder trouble	Bed wetting
Excessive/scanty/painful	Kidney infection/stones	Prostatitis
Discolored/blood/pus	Impotency	

FEMALE

Periods-painful/excessive	Hot flashes	Menopause symptoms
Irregular/cramps	Breasts-lumps/congested	Pregnant yes no

13. Es-En	Sleeps: PR / SUP / LSD / RSD / ALL -- OK -	R L Handed	Rx Lenses No Yes
14. PC-A/S		Smoker No Yes	
15. PC-PS/CS	Bro _____ Sis ____	HBP No Yes Rx	
16. HL	Parents:	Diabetes	
17. TE-DEP	Children:	CA	
		Strokes	

Last exam _____

Delta Rx _____