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____