CONFIDENTIAL PATIENT INFORMATION

TELL US ABOUT YOU (Please Print Clearly)

Name:				
Home Phone #:		Cell Phone #:		
Street Address:				
City:		State:	Zip Code:	
Date of Birth: / /	Age:	Sex: M F	Marital Status M S D W	# of children:
E-mail Address: @			Social Security#: - -	
Whom may we thank for referring you to our office?				
Your Occupation (Current or Previous)				Retired: Y N
Current or Previous Work→	Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N	Heavy Labor: Y N

INSURANCE INFORMATION

Do you have insurance → Yes ___ No ___		If yes, does it require a referral from your doctor → Yes __ No __	
Are your symptoms from a car accident → Yes ____ No ____		Date of accident? / /	
Insurance Company:		ID #:	
Group Name:		Group #:	
Insured's Name (If not patient)		Birthdate:	Social Security #:
Patient Relationship to Insured Party:	Self _____	Spouse _____	Child _____	Other:

HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE COMPANY AND THE PATIENT. THEY ARE DESIGNED TO OFFSET A PORTION OF THE TOTAL COST OF HEALTH CARE. IT IS UNDERSTOOD THAT ALL SERVICES FURNISHED ARE CHARGED DIRECTLY TO THE PATIENT WHO IS PERSONALLY RESPONSIBLE.

Payment is expected at the time of visit unless other arrangements have been made.

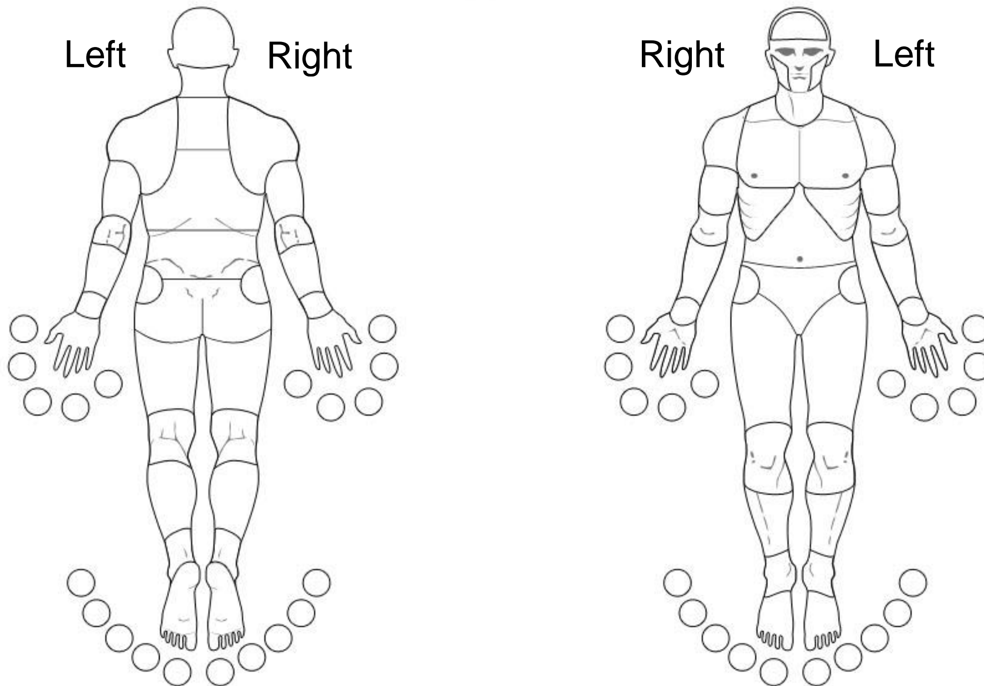
I hereby authorize my insurance benefits to be paid directly to SHORE CHIROPRACTIC and agree that I am financially responsible for any non-covered services. I also authorize the doctors to release any information to my insurance carrier concerning my condition or treatment.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

Patient Signature ____________________________________ Date ______________________

WHAT KIND OF PROBLEM ARE YOU HAVING?

Circle any problem area(s) on the body schematic below and then provide details in the section(s) that follows.



Give us some details here on just the main problem you would like us to look at ➞	Describe the main problem here and then fill in the boxes below:

When did this begin?	If you are not sure give us your best guess >									
Location	☐ Left	☐ Right	☐ Both	☐ Center						
Symptom Rating	0	1	2	3	4	5	6	7	8	9	10 worst
Frequency	☐ Infrequent < 25%	☐ Occasional 25% to 50%	☐ Frequent 50% to 75%	☐ Constant > 75%						

What does it feel like? (Circle one or more)						
	Pain	Ache	Sore	Burning	Kinked	Numbness
	Sharp	Tight	Stabbing	Grabbing	Locked up	Pins & Needles
	Dull	Stiff	Throbbing	Catching	Spasm	Tingling
	Other description ➞					

What makes it better?							
	☐ Medication	☐ Lying Down	☐ Standing	☐ Sitting	☐ Stretching	☐ Motion	☐ Nothing
	Other ➞						

What makes it worse?					
	Nothing	Lifting	Sleep	Sneeze/Cough	Noise
	Standing prolonged	Moving wrong	Exercise	Computer work	Stress
	Sitting prolonged	Slouching	Household work	Neck flexion	Bright lights
	Other ➞				

Does this problem radiate anywhere? ☐ No						
	Neck	☐ Back head	☐ Front head	☐ Entire head	☐ Behind eyes	
		☐ Left arm	☐ Right arm	☐ Left hand/fingers	☐ Right hand/fingers	
		☐ Upper back	☐ Lower back	☐ Left shoulder	☐ Right shoulder	
	Mid back	☐ Left shoulder	☐ Right shoulder	☐ Left arm	☐ Right arm	
		☐ Chest	☐ Lower back	☐ Straight thru	☐ Wraps around	
	Low Back	☐ Left butt	☐ Left thigh	☐ Left calf	☐ Left foot	☐ Left toes
		☐ Right butt	☐ Right thigh	☐ Right calf	☐ Right foot	☐ Right toes

Primary area continued . . . . ↓

Which of the following is true?	☐ It's getting better on its own	☐ Staying the same	☐ It's getting worse as time goes by
What do you think is causing it?			
What is it like at its worst?			
Any additional details or information?			

Is there another area you would like us to look at ➞	Describe any 2nd **problem** here and then fill in the boxes below:										
When did this begin?											
Location	☐ Left		☐ Right			☐ Both		☐ Center			
Symptom Rating	0	1	2	3	4	5	6	7	8	9	10 worst
Frequency	☐ Infrequent < 25%		☐ Occasional 25% to 50%			☐ Frequent 50% to 75%		☐ Constant > 75%			

What does it feel like? (Circle one or more)						
	Pain	Ache	Sore	Burning	Kinked	Numbness
	Sharp	Tight	Stabbing	Grabbing	Locked up	Pins & Needles
	Dull	Stiff	Throbbing	Catching	Spasm	Tingling
	Other description ➞					

What makes it better?							
	☐ Medication	☐ Lying Down	☐ Standing	☐ Sitting	☐ Stretching	☐ Motion	☐ Nothing
	Other ➞						

What makes it worse?					
	Nothing	Lifting	Sleep	Sneeze/Cough	Noise
	Standing prolonged	Moving wrong	Exercise	Computer work	Stress
	Sitting prolonged	Slouching	Household work	Neck flexion	Bright lights
	Other ➞				

Does this problem radiate anywhere? ☐ No						
	Neck	☐ Back head	☐ Front head	☐ Entire head	☐ Behind eyes	
		☐ Left arm	☐ Right arm	☐ Left hand/fingers	☐ Right hand/fingers	
		☐ Upper back	☐ Lower back	☐ Left shoulder	☐ Right shoulder	
	Mid back	☐ Left shoulder	☐ Right shoulder	☐ Left arm	☐ Right arm	
		☐ Chest	☐ Lower back	☐ Straight thru	☐ Wraps around	
	Low Back	☐ Left butt	☐ Left thigh	☐ Left calf	☐ Left foot	☐ Left toes
		☐ Right butt	☐ Right thigh	☐ Right calf	☐ Right foot	☐ Right toes

Which is true?	☐ It's getting better on its own	☐ Staying the same	☐ It's getting worse as time goes by
Any additional details?			

Is there a third area or complaint you would like us to look at →	List your 3rd **problem** here and then fill in the boxes below:										
When did this begin?											
Location	☐ Left			☐ Right			☐ Both			☐ Center	
Symptom Rating	0	1	2	3	4	5	6	7	8	9	10 worst
Frequency	☐ Infrequent < 25%			☐ Occasional 25% to 50%			☐ Frequent 50% to 75%			☐ Constant > 75%	
What does it feel like? (Circle one or more)	Pain	Ache	Sore	Burning	Kinked	Numbness					
	Sharp	Tight	Stabbing	Grabbing	Locked up	Pins & Needles					
	Dull	Stiff	Throbbing	Catching	Spasm	Tingling					
	Other description →										
What makes it better?	☐ Medication	☐ Lying Down	☐ Standing	☐ Sitting	☐ Stretching	☐ Motion	☐ Nothing				
What makes it worse?	Nothing	Lifting	Sleep	Sneeze/Cough	Noise						
	Standing prolonged	Moving wrong	Exercise	Computer work	Stress						
	Sitting prolonged	Slouching	Household work	Neck flexion	Bright lights						
Does this problem radiate anywhere? ☐ No — Neck	☐ Back head	☐ Front head	☐ Entire head	☐ Behind eyes							
Neck	☐ Left arm	☐ Right arm	☐ Left hand/fingers	☐ Right hand/fingers							
Neck	☐ Upper back	☐ Lower back	☐ Left shoulder	☐ Right shoulder							
Mid back	☐ Left shoulder	☐ Right shoulder	☐ Left arm	☐ Right arm							
Mid back	☐ Chest	☐ Lower back	☐ Straight thru	☐ Wraps around							
Low Back	☐ Left butt	☐ Left thigh	☐ Left calf	☐ Left foot	☐ Left toes						
Low Back	☐ Right butt	☐ Right thigh	☐ Right calf	☐ Right foot	☐ Right toes						
Which of the following is true?	☐ It's getting better on its own	☐ Staying the same	☐ It's getting worse as time goes by								
Any additional comments?											

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the patient and the doctor.

This form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature ______________________________________ Date ________________________