

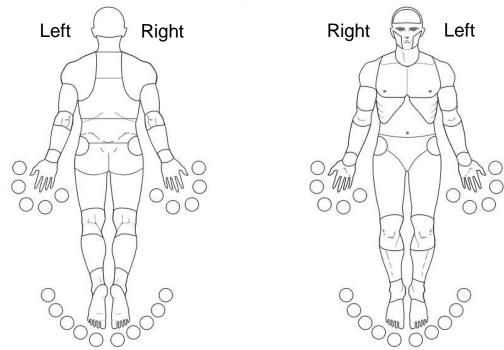
CONFIDENTIAL PATIENT INFORMATION

TELL US ABOUT YOU (Please Print Clearly)

TELL US ABOUT YOU (Please	Trint Cicarry)	/									
Name:											
Home Phone #:		Cell Phone #:									
Street Address:											
City:		State:				Zip Co					
Date of Birth: / /	Age:	Sex	x: M	M F Marital Status M S			D W	f children:			
E-mail Address:	ess:					Social Sec	urity#:				
Whom may we thank for	referring yo	u to	our	office?							
Your Occupation (Current or Pro	evious)								Retired: Y N		
Current or Previous Work→ C	Current or Previous Work→ Clerical: Y N Light Labor: Y N Moderate Labor: Y N Heavy Labor: Y										
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:	icoldoni / 1 o	<u></u>	110) #:		,	,		
Group Name:				Group #:							
Insured's Name (If not patient)				Birthdate: Social Security #:							
Patient Relationship to Insured I	Party: Self		Sı	Spouse Child			l	Othe			
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											

WHAT KIND OF PROBLEM ARE YOU HAVING?

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



just the <u>m</u>	ome detail nain proble e us to lool	<u>n</u> you																								
When did th	nis begin?	If you a	you are not sure give us your best guess >																							
Location			☐ Left			□R	ght			□Во	th		□ Center													
Symptom F	Rating	0 1 2		2 3		4	5		6		7 8			9	10 worst											
Frequency	□lr	freque	nt < 25%	% □Occ	asional	25%	to 50	%	Frequ	uent	50% to	75%	75% Consta		nt > 75%											
		Pain A			Ache	Sore	Sore B			9	Kinked			Numbness												
What does it feel like? (Circle one or more)		Sharp			Tight	tabbin	g		Grabbin	ng Locked (cked up	Pins & N		& Needles											
		Dull			Stiff	robbir	ng		Catchin	ng Spasm			Tingling													
		Other description →																								
What makes it better?		□ Medio	cation	□Lyi	ing Down ☐ Standing ☐ Sit					ting Stretching Motion						Nothing										
vviiat iiiakes	Other →																									
	Nothing			Liftin	Sleep				Sneeze/Cough			Noise														
What makes it worse?		Standing prolonged			Moving v	Exercise				Con	mputer work			Stress												
		Sitting	prolor	nged	Slouch	Household work			ork	Ne	ck flex	tion	Bright lights													
		Other →																								
	Neck	☐ Back head ☐ Front head ☐ Entire head ☐ Behind eyes																								
Does this		☐ Left arm ☐ Right arm ☐ Left hand/fingers ☐ Right hand/fingers																								
problem			er bad	ck 🗆	Lower ba	ick [□ Lef	tsho	ould	er		Righ	t should	der												
radiate anywhere?	Mid back	☐ Left shoulder ☐ Right shoulder ☐ Left arm ☐ Right arm																								
anywheres	Mid back	☐ Che	st 🛮	Lower	back 🗆	l Strai	ght th	nru	□ V	Vraps a	arou	nd														
□No	Law Daal	□Left	butt		eft thigh.		Left	calf		Left f	oot		Left to	es												
	Low Back	□Righ	t butt	□R	ight thigh	1 🗆	Righ	t cal	f [□Right	foo	t C	Right	toes		□ Right butt □ Right thigh □ Right calf □ Right foot □ Right toes										

Primary area continued ↓

					J					• •	•							
Which of th	☐ It's	ו כ	☐ Staying the same ☐						☐ It's getting worse as time goes by									
What do y causi																		
What is its we																		
Any ad detai inform	ils or																	
	nother area	_	Des	scribe	any	2 nd p	orob	lem l	nere	ar	nd the	n fil	l in th	e box	es b	elow	r:	
When did th	nis begin?																	
Location		[Left			□R	ight			□В	oth			Cen	nter			
Symptom Ra	ating	0	1		2	3		4	5		6		7	8		9	10 worst	
Frequency		□In	freque	nt < 25°	% 	Occa	sional	25% to	o 509	%	Fred	quent	50% to	75%		Consta	int > 75%	
		Pain /		Ache			Sore			Burnir	Burning			Kinked Nun				
What does it	feel like?	Shai	rp		Tight S			Stabbing			Grabbi	ng	Lo	ocked u	р	Pins	& Needles	
(Circle one c	or more)	Dul	I		Stiff T			Throbbing Ca			Catchi	atching Spas			m Tingling			
	Other description →																	
What makes it better?		□ Medic	ing Down 🗆 S			anding		Sitt	ing	☐ St	retchin	g 🗆	Motio	on [☐ Nothing			
vvnat makes	it better?	Other →																
		Nothing			Lifting			Sleep				Sneeze/Cough				Noise		
140		Standing prolonged			Moving wrong			Exercise				Computer work			Stress			
what makes	What makes it worse?		Sitting prolonged Slouching Household work Neck flexion Bright lights										nt lights					
		Other →																
		☐ Back head ☐ Front head ☐ Entire head ☐ Behind eyes																
Does this	Neck	□ Left :				t arm					ngers			t hand		ers		
<u>problem</u> radiate		□ Upper back □ Lower back □ Left shoulder □ Right shoulder □ Left arm □ Right arm																
anywhere?	Mid back												ht arr	n				
□No		□ Ches						<u> </u>			Vraps							
Пио	Low Back		□ Left butt □ Left thigh □ Left calf □ Left foot □ Left toes															
\A(I : 1 :		□Righ				thigh		Right			∃Righ			Righ				
Which	Which is true?			g bette	r on it	ts own	L	∃ Stay	ing 1	the s	same		it's ge	tting w	orse	as tim	ne goes by	
Any ad																		

	Is there a area or co you would to look at	omplaint d like us	List your 3	^{gra} prol	olem hei	e and	then fil	I in th	ie boxes	below	V:			
	When did th	nis begin?												
	Location				□Ri	Right		☐ Both			Center			
	Symptom Rating		0 1	:	2 3		4	5	6	7 8		9	10 worst	
	Frequency		☐ Infrequ	ent < 25°	% □ Occ	asional	25% to 50	% [Frequent	50% to	50% to 75% Constant			
			Pain	Ache		Sore	Е	Burning	K	inked	N	umbness		
	What does it feel like? (Circle one or more)		Sharp	Tight		tabbing		rabbing		ked up	Pins & Needles			
			Dull	Stiff	Th	robbing	С	atching	S	pasm		Tingling		
			Other descrip	Other description →										
	What makes	it better?	☐ Medication	ng Down	□Sta	anding [Sittin	ig 🗆 Str	etching \square N		lotion			
			Nothin	Liftin	g	Sle	еер	Sne	eeze/Cough		Noise			
	What makes it worse?		Standing pro	Moving v	vrong	Exe	rcise	Con	nputer w	/ork	Stress			
			Sitting prole	Slouch	ing	Househ	old wo	rk Ne	eck flexio	on	Bright lights			
			□ Back head □ Front head □ Entire head □ Behind eyes											
	Does this	Neck	□ Left arm □ Right arm □ Left hand/fingers □ Right hand/fingers □ Upper back □ Lower back □ Left shoulder □ Right shoulder											
	<u>problem</u> radiate		☐ Upper back ☐ Lower back ☐ Left shoulder ☐ Right shoulder ☐ Left shoulder ☐ Right shoulder ☐ Left arm ☐ Right arm											
	anywhere?	Mid back	□ Chest □ Lower back □ Straight thru □ Wraps around											
	□No		□ 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 is true?	☐ It's getting better on its own ☐ Staying the same ☐ It's getting worse as time goes to										ne goes by	
	Any ad comm													
re	ealth servi This sponsibili	ces are ba form wa ty to infor	to discuss sed on a fr s complete m this offi	iendly, ed corr ce of a	mutual rectly to any chan	unde the ges in	erstanding best of n my m	ng be my edica	knowle	he par dge. I urance	tient a Lunde statu	and the erstand as.	doctor. it is my	
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