

1 **PATIENT INFORMATION**

Date _____

SS#/Patient ID# _____

Patient Name _____
Last Name _____
First Name _____ Middle Name _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birth date _____

Married Widowed Single / Minor
 Separated Divorced
 Partnered

Patient Employer / school _____

Occupation _____

Employer / School Address _____

Employer/School Place _____

Spouse's / Partner's Name _____

Birth date _____

SS# _____

Spouse's/Partner's Employer _____

Whom may we thank for referring you ? _____

2 **ASSIGNMENT AND RELEASE**

Who is responsible for this account ? _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance?
 Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I certify that I am, and/or my dependent(s), have insurance coverage _____ and assign directly to _____ Name of insurance Company(ies) _____

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 Companies and 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 _____

Please print name of Patient, Parent Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

3 **PHONE NUMBERS**

Cell Phone(_____) _____ Home Phone(_____) _____

Best time and place to reach to you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 **ACCIDENT INFORMATION**

Is condition due to an accident ? Yes No Date _____

Type of accident Auto Work Home Other

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5 **PATIENT CONDITION**

Reason for Visit _____

When did you symptoms appear ? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling

Rate the severity of you pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

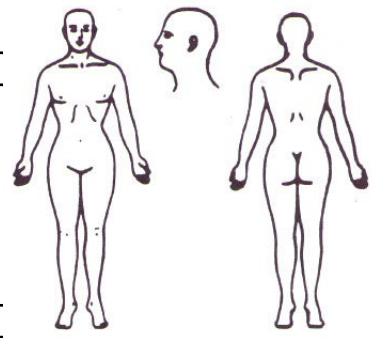
Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain ? _____

Is it constant or does it come and go ? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition. _____

Date of Last:
 Physical Exam _____ Spinal X-ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-scan, Bone Scan _____ Chiropractic Services _____

Place a mark on Yes or No to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking Packs/Day _____
- Alcohol Drinks Week _____
- Coffee/Caffeine Drinks Cups/Day _____
- High Stress Level Reason _____

Are you pregnant ? Yes No Due Date _____

Injuries / Surgeries you have had	Description	Date
Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____

7

MEDICATIONS

 Pharmacy Name _____
 Pharmacy Phone (_____) _____

ALLERGIES

VITAMINS / HERBS/MINERALS

