PATIENT INFORMATION

Date____

SS/HIC/Patient ID#______________________________

Patient Name ___________________________________
Last Name

____
First Name Middle Initial

Address ____

City____

State______________________ Zip_________________

E-mail____

Sex ☐ M ☐ F Age_________

Birthdate _______________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______Years

Patient Employer/School_________________________

Occupation______________________________________

Employer/School Address_________________________

____

Employer/School Phone (_____)___________________

Spouse's Name___________________________________

Birthdate_______________________________________

SS#____

Spouse's Employer ______________________________

Whom may we thank for referring you?

____

INSURANCE INFORMATION

Who is responsible for this account ?___________________

Relationship to Patient_________________________________

Insurance Co.____

Policy #____________________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, and/or my dependent(s), have insurance coverage with ________________________________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 aboce-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) 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

PHONE NUMBERS

Cell Phone (____)_____________ Home (____)______________

EMERGANCY CONTACT

Name______________________ Relationship_______________

Home(____)_________________ Cell (____)_________________

ACCIDENT INFORMATION

Is condition due to accident? ☐Yes ☐ No Date________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

PATIENT CONDITION

Reason for Visit____

When did your symptoms appear?____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

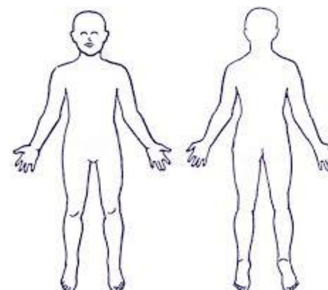
Mark and X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (lease 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?___________________________________



HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medication ☐ 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______________________________

Place circle the "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No	Pheumatic Fever	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Scarlet Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Migraine Headaches	Yes	No	Sexually Transmitted Disease	Yes	No
Anemia	Yes	No	Fracture	Yes	No	Miscarriage	Yes	No			
Anorexia	Yes	No	Glaucoma	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Multiple Sclerosis	Yes	No	Suicide Attempt	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Mumps	Yes	No	Thyroid Problems	Yes	No
Asthma	Yes	No	Gout								
Bleeding Disorders	Yes	No	Heart Disease	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Breast Lump	Yes	No	Hepatitis	Yes	No	Pacemaker	Yes	No	Tuberculosis	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Parkinson's Disease	Yes	No	Tumors, Growths	Yes	No
Bulimia	Yes	No	Herniated Disc	Yes	No	Pneumonia	Yes	No	Typhoid Fever	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Polio	Yes	No	Ulcer	Yes	No
Cataracts	Yes	No	High Blood Pressure	Yes	No	Prostate Problem	Yes	No	Vaginal Infections	Yes	No
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Prosthesis	Yes	No	Whooping	Yes	No
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Psychiatric Care	Yes	No	Other______________		

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day______________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week______________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Dinks	Cups/Day______________
☐ Heavy	☐ Heavy Labor	☐ 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 ______________	______________	______________

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
______________	______________	______________
______________	______________	______________
Pharmacy Name______________	______________	______________
Pharmacy Number (____)______________	______________	______________