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

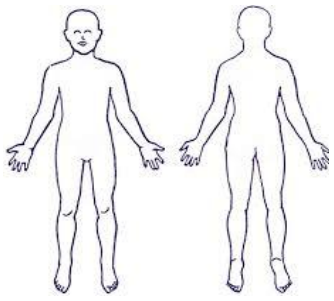
Mark and X on the picture where you continue to have pain, numbness, or tingling.

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

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day_____
- ☐ Alcohol — Drinks/Week_____
- ☐ Coffee/Caffeine Dinks — Cups/Day_____
- ☐ High Stress Level — Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name_____	_____	_____
Pharmacy Number (____)_____	_____	_____