PATIENT INFORMATION

PATIENT NAME

Last Name _____First Name _____ Middle _____
Gender: M F Date of Birth ____ / ____ / ____ Age _____ SS# _____
Home Address _____ Apt #_____
City _____ State_____ Zip_____
Home Phone # _____ Cell Phone # _____ Work Phone #_____
Email Address: _____
Marital Status M D S W Ethnicity: _____ Preferred Language: _____
Employer Name _____ Occupation_____
Employer Address _____ Suite # _____
City _____ State_____ Zip_____
Work Status: Full-Time Part-Time Retired Other Not Employed
Have you ever been under Chiropractic care? _____
If yes, give name and location of doctor _____

SPOUSE or GUARDIAN

Last Name _____ First Name _____ Middle _____
Employer Name _____ Cell Phone # _____Work Phone # _____
Date of Birth ____ / ____ / ____ SS# _____

EMERGENCY Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _____ Middle _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Relation to Patient _____

INSURANCE INFORMATION

INSURANCE We need a copy of your card(s) for our records.

Insurance Company _____ Phone # _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # _____
Insured's Name _____ ID/Policy # _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____
Relationship to Patient _____ SS# _____
Home Address _____ Apt# _____
City _____ State _____ Zip_____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Employer Name _____ Occupation _____

WHO MAY WE THANK FOR REFERRING YOU? _____

Date of Visit: ___/___/____ Patient: _____ DOB: _____

What brought you here today?_____
Date symptoms appeared or accident happened __/___/___ Have you ever had a similar condition? Y N
If yes, explain _____
What activities aggravate this? _____
Are you getting progressively worse? Y N
Is this condition interfering with: ___ work ___Sleep ___Daily Routine ___Other _____
How long has it been since you really felt good? _____

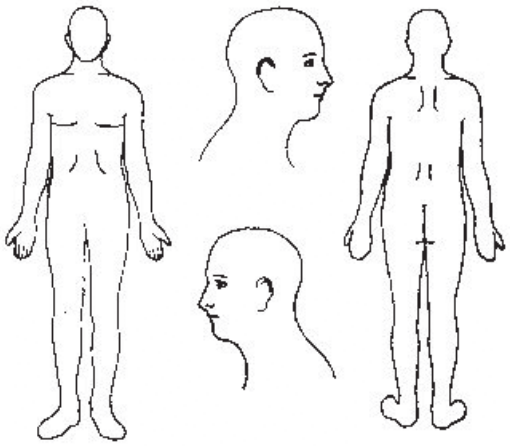
Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles

PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE



Describe your past health history:
Prior Illness: _____
Past Hospitalizations: _____
Surgeries: _____
Allergies: _____
Medications: _____
Vitamins & Minerals: _____

Other History (Circle the one of the Items Listed Beside Each Category)

Tobacco: Never Smoker Current Smoker Former Smoker Current Every Day Smoker Current Some Day Smoker
Caffeine: (Circle One of the Items Listed Below)
None <3 Drinks/Day 3-6 Drinks/Day >6 Drinks/Day
Alcohol: None Casual Drinker Moderate Drinker Heavy Drinker Drinks Beer Drinks Wine
Drugs: None Recreational User Addiction
Exercise: Never Daily Weekly Walks Runs Swims

Are you pregnant? Yes No If yes, What is your due date?_____
Date of last physical exam_____
How is your overall health?_____

Date of Visit: ___/___/____ Patient: _____ DOB: _____

Have you ever suffered from or diagnosed with any of the following: Check all that apply.

Cardiovascular System:
__High Blood Pressure
__Low Blood Pressure
__Slow heart beat
__Chest pain
__Congenital Heart Defect
__Bruise easily
__Poor Circulation
__Swelling of Ankles
__Arteriosclerosis
__Nose Bleeds
__Pain over heart
__Varicose veins
__Irregular Heart Beat
__Pacemaker
__Difibrillator
__Heart Surgery
__Anemia
__Hemophilia
__Rapid heartbeat

Digestive System:
__Ulcers
__Diarrhea
__Liver Trouble
__Constipation
__Difficult Digestion
__Hemorrhoids
__Colon Trouble
__Nausea
__Hepatitis

Miscellaneous:
__Hives
__Breast Implants
__Loss of Sleep
__Handicaps/Disabilities
__Gout

Neurological System:
__Eye Pain
__Eye Twitching
___Anxiety
__Depression
__Dizziness
__Nervousness
__Ringing in Ears
__Memory Loss
__Loss of Balance
__Loss of Smell
__Loss of Taste
__Hearing Impairment
__Headache
__Numbness
__Deafness
__Epilepsy
__Stroke
__Shingles
__MS

Muscular & Skeletal System:
__Bursitis
__Artificial Bones/Joints/Valves
__Foot Trouble
__Poor Posture
__Spinal Curves
__Osteoporosis
__ Fibromyalgia
__Muscle Spasms
__Cramps/backache
__Arthritis
__Sciatica
__Swollen Joints
__Fractured Bone

Endocrine System:
__Diabetes
__Fatigue
__Lupus
__Thyroid
__ Enlarged Thyroid

Diseases:
__Polio
__Alcoholism
__ADD
__ADHD
__Cancer
__HIV
__Chicken Pox

Urinary System:
__Frequent Urination
__Kidney Infection
__Prostate trouble
__Bed-Wetting
__Kidney Stone

Reproductive System:
__Hot flashes
__Irregular cycle
__Lumps in breast
__Miscarriage
__Excessive Menstruation

Respiratory System:
__Allergy
__Tuberculosis
__Pleurisy
__Asthma
__Sinus Infection
__Bronchitis
__Pneumonia
__Emphysema
__Difficulty Breathing

Date of Visit: ___/___/____ Patient: _____ DOB: _____

Have you had the following:

Bone Density: Date of Test _____ Results _____

Mammogram: Date of Test _____ Results _____

Family History:

List any illnesses such as Arthritis, Diabetes, Cancer, High Blood Pressure, Stroke, Thyroid, etc.

Mother _____

Father _____

Mat. Grandmother_____

Mat. Grandfather _____

Pat. Grandmother _____

Pat. Grandfather _____

Siblings:

How many: _____

Health issues: _____

_____

_____

Children:

How many: _____

Health issues: _____

_____

_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in status of the above information.

I also understand that I will be held responsible for all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies, such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

I will also be responsible for 1.75% monthly interest on unpaid balance.

I authorize any third party payment due myself or any representative to be made directly to this office or Doctor.

I hereby authorize the Doctor to treat my condition, as she sees appropriate through the use of manipulation throughout my spine. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient Signature_____Date__/___/____

Parent (if minor) _____ Date__/___/____