

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

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, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an 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

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your 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 your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

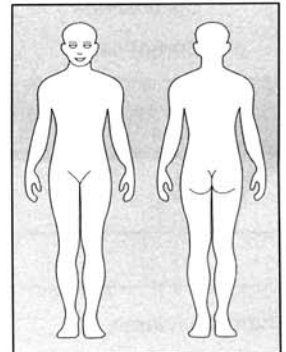
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  
 Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other

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



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 \_\_\_\_\_

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

**MEDICATIONS**

**ALLERGIES**

**VITAMINS/HERBS/MINERALS**

Pharmacy Name \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_