PATIENT INFORMATION

File#:_____

Name _____ **Today's Date** _____

Address _____ City _____ Zip _____

Phone 1 _____ Phone 2 _____ Status: S M D W

Date of Birth _____ SSN: _____ DL# _____

Email _____ Referred by? _____

Occupation _____ How long? _____
Employer: _____
Address _____ City _____ Zip _____

Finances [ ] I have no insurance and will pay by Cash, Check or Credit Card today [ ] I have insurance
(Please note that by law we MUST collect co-pays and deductibles at time of service if you have insurance)

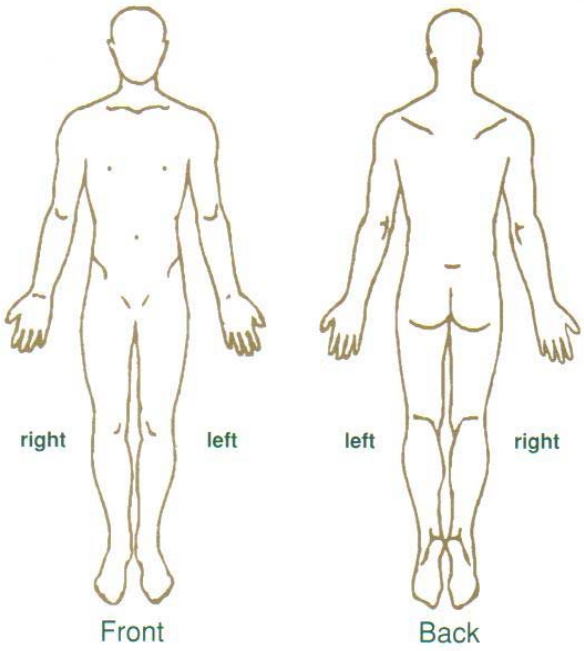
Primary Insurance _____ Memb ID#:_____

Secondary Insurance _____ Memb ID#:_____

Tell us about your condition:
Height _____ Weight _____ Dominant Hand? R L

Please mark area(s) of pain or discomfort on the figures below. Mark all areas with a descriptive symbol and a number for severity of pain or distress on a 1 (minimal discomfort) to 10 (excruciating pain) scale.

Description: Numbness NNN, Pins & Needles PPP, Burning BBB, Aching AAA, Stabbing SSS, Electric EEE
Other: _____



When did it start? _____ How did it start? _____
_____
_____
Have you had similar problems in the past? When? _____
_____
Have you seen a Doctor of Chiropractic in the past? _____
Name and last visit: _____

File#:_____

Health History

Are you taking any of these medications?

[ ] Nerve pills [ ] Pain killers [ ] Aspirin/Ibuprofen/Tylenol/Aleve [ ] Muscle Relaxers [ ] Stimulants [ ] Blood Thinners [ ] Insulin
[ ] Tranquilizers [ ] Other: _____

Do you now or have you ever had any of these conditions?

Y N Heart attack/stroke	Y N Heart surgery/Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral valve prolapse	Y N Artificial valves
Y N Alcohol/Drug abuse	Y N Venereal disease	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/TB	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back problems	Y N Artificial Bones/Joints	Y N Arthritis

List any previous accidents/injuries:

_____

_____

List any other serious medical conditions you may have or ever had:

_____

_____

_____

List any allergies you may have:

_____

_____

List previous surgeries with dates:

_____

_____

Take Vitamin/Nutritional supplements? List:

_____

Significant Family Medical History:

_____

_____

Are you pregnant? Y N **LMP:** _____ **Taking Birth control pills?** Y N **Type/How Long?** _____

Are you on any special diet? Y N How long? _____ **wks/mos/yrs Describe:**

_____

Do you smoke? Cigarettes? Y N **Cigars?** Y N **Pipe?** Y N **How many/How Often?** _____

Authorization for Treatment: *"I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information provided."*

*Signature*_____ *Date:* _____

Assignment of Benefits/Direct Payment to Provider: "*I hereby authorize assignment of my insurance rights and benefits and order any insurance company making payments on my behalf to do so directly to the provider."*

*Signature*_____ *Date:* _____