



Patient Name _____ Date _____

Date of Birth ___/___/___ Social Security # _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip _____

Telephone: _____ Work Phone: _____ Email _____

Occupation _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name: _____ Insurance Company: _____

Subscriber's Date of Birth ___/___/___ Subscriber's SS # _____ Relationship _____

Subscriber ID#: _____ Group#: _____

Referred to this office by: _____
Name Tel # Address

Primary Physician _____ Address _____

Office Name: _____ Telephone: _____ Fax: _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness

Are you in pain: Yes No Rate your pain with the following scale:

No _____ The Worst
Pain _____ Imaginable Pain

Did your injury occur during: Work Sports/Play Auto Accident Routine/Household Activity

When did your condition / accident occur? ___/___/___ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes

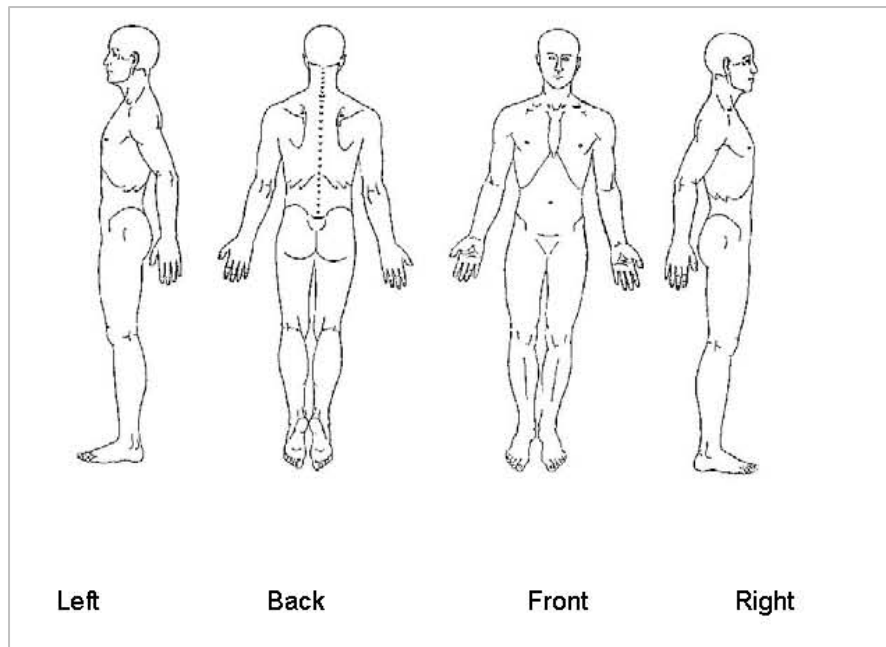
Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Have you been treated by a medical physician for this pain? Yes No If so, where? _____

Have you ever been treated by a chiropractor? Yes No Clinic or Dr's Name _____

Clinic Address: _____ Clinic Phone: _____

Using the adjacent body charts, please circle all affected areas:



Please list any medications you may be taking: _____

Do you have or have you had any of the following diseases, medical conditions or procures?

- | | | | |
|-------------------------|--------------------------------|-------------------------|-----------------------------|
| Y N Heart Attack/Stroke | Y N Heart/Surg./Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect |
| Y N Artificial Valves | Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N Anemia / Diabetes | Y N Shingles | Y N Cancer | Y N Frequent Neck Pain |
| Y N Glaucoma | Y N Kidney Problems | Y N H/L Blood Pressure | Y N Psychiatric Problems |
| Y N Rheumatic Fever | Y N Sever / Frequent Headaches | Y N Tuberculosis | Y N Ulcers / Colitis |
| Y N Fainting | Y N Seizures / Epilepsy | Y N Sinus Problems | Y N Emphysema / Asthma |
| Y N Arthritis | Y N Difficulty Breathing | Y N Lower Back Problems | Y N Artificial Bones/Joints |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes ____ hrs/week

Do you smoke? Yes No How much? _____ How Long? _____



Are you wearing: Shoe Lifts Inner Soles Arch Supports Are you dieting: No Yes

For Women: Are you taking Birth Control? Yes No

Are you pregnant? Yes No If so, how many weeks? _____ Are you nursing? Yes No

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- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
 - Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business/office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
 - 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 this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

Adult Patient Parent or Guardian Spouse