# WELCOME

## 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

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

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 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 above-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

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

## 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 _____

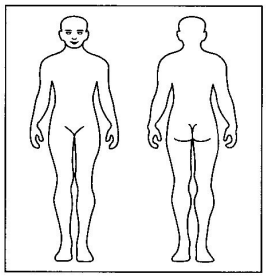
When did your symptoms appear? _____

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

## HEALTH HISTORY

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 | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Rheumatic 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 | Fractures | ☐ 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 | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Bleeding Disorders | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Breast Lump | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No | Parkinson's Disease | ☐ Yes ☐ No | Tumors, Growths | ☐ Yes ☐ No |
| Bronchitis | ☐ Yes ☐ No | Hernia | ☐ Yes ☐ No | Pinched Nerve | ☐ Yes ☐ No | Typhoid Fever | ☐ Yes ☐ No |
| Bulimia | ☐ Yes ☐ No | Herniated Disk | ☐ Yes ☐ No | Pneumonia | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Polio | ☐ Yes ☐ No | Vaginal Infections | ☐ Yes ☐ No |
| Cataracts | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Prostate Problem | ☐ Yes ☐ No | Whooping Cough | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No | Prosthesis | ☐ Yes ☐ No | Other _____ | |
| Chicken Pox | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | | |
| | | | | Rheumatoid Arthritis | ☐ Yes ☐ 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 (_____)_____ | | |