

Welcome

PATIENT INFORMATION	INSURANCE
Date	Who is responsible for this account?
SS/HIC/Patient ID #	Relationship to Patient
	Insurance Co.
	Group #
Patient Name	Is patient covered by additional insurance? ☐ Yes ☐ No
Last Name First Name M. I.	Subscriber's Name
Address	Birthdate SS#
CityStateZip	Relationship to Patient
E-mail	Insurance Co.
Sex M F Age Birthdate	Group #
☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered foryears	ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with
Occupation	Name of Insurance Company(ies) and assign directly to
	Dr all insurance benefits, if
Patient Employer/School Employer/School Address	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
Employer/School Phone ()	such information to the above-named Insurance Company(ies) and their agen- for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end whe my current treatment plan is completed or one year from the date signed below
Spouse's Name	
opouses mane	
Birthdate	Signature of Patient, Parent, Guardian or Personal Representative
SS#	Please print name of Patient, Parent, Guardian or Personal Representative
Spouse's Employer	These plint having on adding, throng generation of a contact approximate
Whom may we thank for referring you?	Date Relationship to Patient
PHONE NUMBERS	ACCIDENT INFORMATION
Home Phone ()	Is condition due to an accident? Tyes No
Cell Phone ()	Date
Best time and place to reach you	Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other
IN CASE OF EMERGENCY, CONTACT Name	To whom have you made a report of your accident?
Relationship	☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other
Home Phone ()	Attorney Name (if applicable)
Work Phone ()	
PATIENT (CONDITION
Reason for Visit	
When did your symptoms appear?	
Is this condition getting progressively worse?	own
Mark an X on the picture where you continue to have pain, numbness, o	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (sever Type of pain: Sharp Dull Throbbing Numbne Burning Tingling Cramps Stiffness	ess Aching Shooting Swelling Other
	nstant or does it come and go?
Does it litteries with John Disease Di	

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 Chicken Pox Liver Disease ☐ Yes ☐ No Yes No ☐ Yes ☐ No Psychiatric Care ☐ Yes ☐ No Alcoholism ☐ Yes ☐ No Diabetes Yes No Measles ☐ Yes ☐ No Rheumatoid ☐ Yes ☐ No Arthritis Allergy Shots ☐ Yes ☐ No Migraine Emphysema Yes No Yes No Rheumatic Fever ☐ Yes ☐ No Headaches Yes No Epilepsy Anemia ☐ Yes ☐ No Scarlet Fever ☐ Yes ☐ No Miscarriage ☐ Yes ☐ No Anorexia Yes No Fractures ☐ Yes ☐ No Stroke ☐ Yes ☐ No ☐ Yes ☐ No Mononucleosis ☐ Yes ☐ No Appendicitis Glaucoma ☐ Yes ☐ No Suicide Attempt ☐ Yes ☐ No Multiple Sclerosis ☐ Yes ☐ No Arthritis Yes No Goiter Yes No Thyroid Problems Yes No Mumps ☐ Yes ☐ No Asthma Yes No Gonorrhea Yes No Tonsillitis ☐ Yes ☐ No Osteoporosis ☐ Yes ☐ No Yes No Bleeding Gout Yes No **Tuberculosis** ☐ Yes ☐ No Disorders Pacemaker ☐ Yes ☐ No **Heart Disease** Yes No Tumors, Growths ☐ Yes ☐ No Breast Lump ☐ Yes ☐ No Parkinson's ☐ Yes ☐ No Hepatitis ☐ Yes ☐ No Typhoid Fever Disease ☐ Yes ☐ No **Bronchitis** ☐ Yes ☐ No Hernia Yes No Pinched Nerve ☐ Yes ☐ No Ulcers ☐ Yes ☐ No Bulimia ☐ Yes ☐ No Herniated Disk ☐ Yes ☐ No Pneumonia ☐ Yes ☐ No Vaginal Infections Yes No ☐ Yes ☐ No Cancer Herpes ☐ Yes ☐ No Polio ☐ Yes ☐ No Venereal Disease ☐ Yes ☐ No Cataracts Yes No High Cholesterol Yes No Prostate Problem Yes No Whooping Cough Yes No Chemical ☐ Yes ☐ No Dependency Kidney Disease ☐ Yes ☐ No Prosthesis ☐ Yes ☐ No Other EXERCISE WORK ACTIVITY **HABITS** ☐ None ☐ Sitting ☐ Smoking Packs/Day_ ☐ Standing ☐ Alcohol Drinks/Week ☐ Light Labor ☐ Coffee/Caffeine Drinks Cups/Day_ ☐ Daily ☐ Heavy Heavy Labor ☐ 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 **ALLERGIES** VITAMINS/HERBS/MINERALS **MEDICATIONS** Pharmacy Name Pharmacy Phone (_