PATIENT INFORMATION: **DATE:**

Name:_____ Home: ( ) _____ Cell: ( ) _____

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

Social Security No._____ Marital Status: S/ M/ D Date of Birth:____/____/_____

Driver's license #:_____ Occupation:_____

Employer:_____

Work Phone: ( ) _____ E-mail address:_____

Name of spouse or nearest relative:_____ Phone #: ( ) _____

How did you learn about us? Yellow pages ____(book name _____) Spanish Yellow pages_____ Newspaper_____

Web____ Tele-marketing____ Sign____ Insurance company____ Other:_____ Referred by:_____

Please check type of care desired: ( ) Lasting Correction ( ) Temporary Relief

What is your major problem?	#1	#2	#3
Describe your pain (sharp, dull, numb, burn, throb, sore, shooting, tingling, weak).			
How long have you had this?			
How did it happen?			
How does this affect your life?			
Does the pain radiate? Travel? Where?			
When do you notice the pain the most?			

Please list any past or present: ( )hospitalization ( )injuries **PLEASE EXPLAIN:**
( ) illnesses ( ) allergies ( ) medications _____
Has anyone in your family had: ( ) arthritis ( ) blood problems _____
( ) cancer ( ) diabetes ( ) genetic disorders _____
What do you do at work? _____ # of hours/week_____
List hobbies/sports:_____

I order my insurance company to pay directly to this chiropractic office and authorize the doctor to treat myself and or children as needed. I authorize the doctor to release records or request records as needed. I understand that I am directly responsible for any changes including deductibles and co-pays. I also understand that this office does not offer to diagnose or treat any disease or condition other than vertebral subluxations (misalignments).

Signature:_____ Date:_____

FOR OFFICE USE ONLY **(Make copy of insurance card)** **Dr. Name**_____

Insurance Co._____ Adjuster_____ Phone #_____

Bills sent to:_____

Name of insured_____ Policy still in effect: Y/ N Date effective:_____

Policy #_____ Group #_____ Chiro: Y/N _____% X-Rays: Y/N _____%

Massage: Y/N_____ PT: Y/N Limit:_____ Supports / Vitamins: Y/N_____

Deductible: Y/N $_____ Amt. Met: $_____ Co-Pay: $_____

Max # of TX: _____ Max Ins. Pay: $_____ # Visits used/ amt used:_____

Referral from PCP? Y/N Name of PCP_____

Authorizations needed? Y/N # TX approved:_____ Time period covered: _____

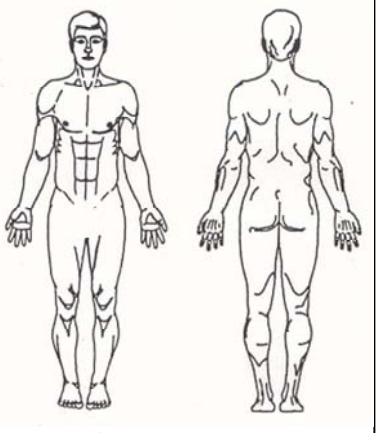
Special instructions: _____

Verified by:_____

PLEASE be thorough & fill out COMPLETELY Date: _____

Name: _____

Symtom Localization



P___ Pain T____ Tender
N___ Numb t____ Tingling
S___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

ARE YOU PREGNANT?

☐ Yes ☐ No

HABITS

- ☐ Cigaretes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Exercise
- ☐ Drug Abuse
- ☐ _____

What else have you tried to alleviate your pain?_____

_____

How does your injury interfere with your:

Social Life_____

_____

Work_____

_____

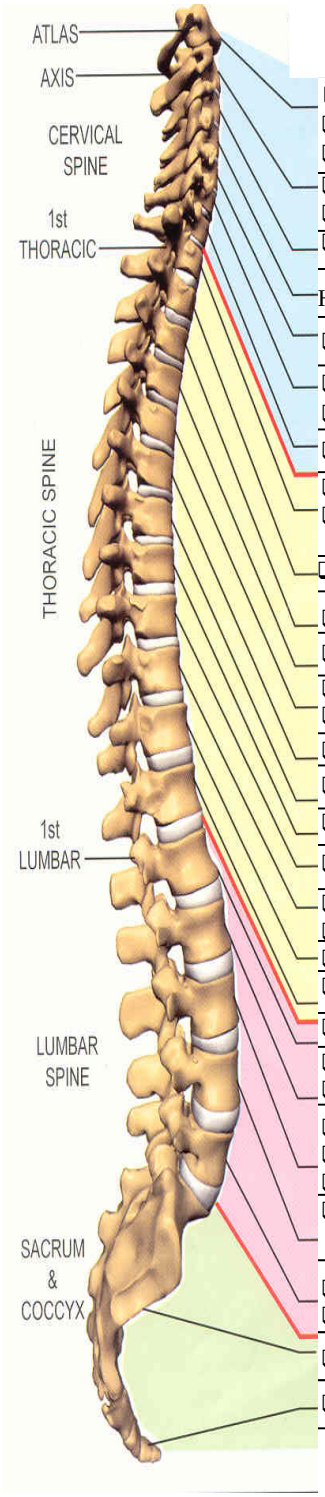
Family_____

_____

How will your life improve when your health improves?_____

_____

_____



PLEASE CHECK OFF ALL THE BOXES THAT APPLY TO YOU

- ❑ Headaches ❑ Nervousness ❑ Insomnia ❑ Nausea ❑ Dizziness ❑ Confusion ❑ Fainting ❑ Head Colds ❑ Chronic tiredness ❑ High blood pressure
- ❑ Stress problems ❑ Allergies ❑ Ear ache ❑ Deafness ❑ Blurry vision
- ❑ Acne or pimples ❑ Nerve pain&/ or inflammation
- Hay fever ❑ Hearing loss ❑ Runny nose
- ❑ Sore throat ❑ Laryngitis ❑ Hoarseness of throat
- ❑ Neck pain ❑ Chronic cough ❑ Tonsillitis ❑ Upper arm pain
- ❑ Colds ❑ Thyroid conditions ❑ Bursitis
- ❑ Lower arm(s) & hand(s) pain ❑ Asthma ❑ Cough ❑ Difficulty breathing ❑ Shortness of breath
- ❑ Chest pain ❑ Functional heart conditions
- ❑ Bronchitis ❑ Pneumonia ❑ Chest congestion
- ❑ Mid back pain ❑ Gallbladder problems ❑ Jaundice
- ❑ Liver problems ❑ Arthritis ❑ Poor circulation ❑ Pain between the shoulders ❑ Fevers
- ❑ Stomach troubles ❑ Indigestion ❑ Heartburn
- ❑ Poor appetite ❑ Ulcer ❑ Gastritis
- ❑ Lowered resistance ❑ Spleen problems
- ❑ Allergies ❑ Hives
- ❑ Chronic tiredness ❑ Kidney problems ❑ Hardening of the arteries
- ❑ Skin conditions ❑ Acne ❑ Eczema ❑ Bolls
- ❑ Rhemnmatism ❑ Sterility ❑ Gas pain
- ❑ Constipation ❑ Diarrhea ❑ Colitis ❑ Hernias
- ❑ Difficulty breathing ❑ Abdominal cramps ❑ Varicose veins ❑ Appendicitis
- ❑ Bladder problems ❑ Menstrual cramps ❑ Impotency ❑ Irregular periods ❑ Bed wetting ❑ Knee pain ❑ Miscarriages
- ❑ Low back pain ❑ Pain down the leg(s) ❑ Difficult, painful or frequent urination
- ❑ Weakness in leg (s) ❑ Poor circulation in leg (s) ❑ Leg cramps ❑ Cold feet ❑ Weak or swollen ankles
- ❑ Walking problems ❑ Spinal curve problems
- ❑ Hemorrhoids ❑ Itching ❑ Tail bone pain

Other symptoms or conditions you would like the doctor to know about:_____

_____

_____

Patient signature: _____