

PATIENT INFORMATION

Date _____ Birth-date _____ SS # _____
First Name _____ Middle Initial _____ Last Name _____
Address _____ City _____ State _____
Zip _____ Sex M F Age _____ Email _____
 Married Single Minor Widowed Divorced
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (_____) _____
Spouse's Name _____ Spouse's Birth-date _____
Spouse's SS # _____ Spouse's Employer _____
How did you hear about us? Website Radio Internet Newsletter Newspaper Family Doctor Billboard
 Yellow Pages – Where? _____ Former Patient – Who? _____ Other _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to Patient _____
Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Co.) and assign directly to 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 for one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____
Print name of Patient, Parent, Guardian or Personal Representative _____
Date _____ Relationship to Patient _____

PHONE NUMBERS

Cell (_____) _____ Home (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

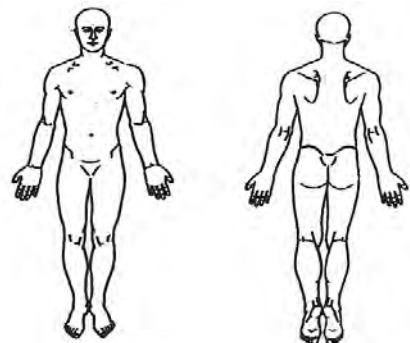
Name _____ Relationship _____ Home (_____) _____ Work (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____ Type of accident: Work Auto Home Other
To whom have you made a report of your accident? Auto Insurance Employer Work Comp. Other
Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____ How often do you have this condition? Constant Occasional Rarely
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 _____
Does your pain radiate? Yes No Where _____
What activities **worsen** your pain? Bending Sleeping Lifting Coughing
 Standing Arising From a Chair Exercising Other
What activities **relieve** your pain? Pain Meds Stretching Sitting Walking
 Standing Heat/Cold Exercising Other



HEALTH HISTORY

Place a mark in the box to indicate if you have had any of the following:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> STD | _____ |

Are you pregnant? Yes No Number of Weeks _____

EXERCISE: Moderately Occasionally Rarely Regularly Never

HABITS: Smoking: Packs/Day _____ Alcohol: Drinks/Week _____

Family Physician: _____ **Date Last Seen:** _____

Results: _____

Medications you are currently taking:

Allergies:

Vitamins / Minerals: _____

Surgical History: Type _____ Where _____ When _____
Type _____ Where _____ When _____

Hospitalizations: Cause _____ When _____ Remaining Problems _____
Cause _____ When _____ Remaining Problems _____

Broken Bones: _____ When _____ Surgeries _____
_____ When _____ Surgeries _____

Previous Tests for THIS Condition:

- | | |
|--|-------------------|
| <input type="checkbox"/> X-Ray Date: _____ | Ordered by: _____ |
| <input type="checkbox"/> MRI Date: _____ | Ordered by: _____ |
| <input type="checkbox"/> Other: _____ | Ordered by: _____ |

RECORD RELEASE AUTHORIZATION

DOCTOR / HOSPITAL _____

ADDRESS _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient's Signature

Date

Patient's Name (Please Print)

If Patient Is A Minor Signature Of Parent Or Legal Guardian

Relationship to Patient

Witness To The Above Signatures

Please Print Name

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed
By patient

Witness