WELCOME

1 one

ABOUT YOU

Today's Date: ____/____/____ File #:_____
Name:_____

What You Prefer to Be Called:_____ ☐Male ☐ Female
Birthdate:____/____/____ Age:_____ SS#: _____
Home Address: _____
City: _____ State:_____ Zip:_____
Home Phone #:_____ Wk#:_____
Employer: _____ How Long? _____
Employer's Address: _____
City:_____ State:_____ Zip: _____
Occupation:_____ Wk Phone #:_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Spouse's Name:_____

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INSURANCE INFO

Co. Name:_____
Address:_____
Phone#:_____
Insured's SS#:_____
Group # (Plan, Local, or Policy #):_____
Insured's Name:_____
Relation:_____
Date of Birth:____/____/____
Insured's Employer:_____
Please Inform front desk of 2nd. Insurance source.

REASON FOR VISIT

When did condition begin?____/____/____
The reason for this visit is a result of (*Please circle*):work, sports,auto, trauma or chronic
(*Explain what happened*): _____
_____
Please describe the pain & its location:_____
_____
Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes
Is this condition interfering with your (*Please circle*): work, sleep, or daily routine.
If so, please explain:_____
Have you had this or similar conditions in the past? ☐Yes ☐No
If so, please explain:_____
Have you ever been treated by a chiropractor before? ☐Yes ☐No
Have you been treated by a Medical Physician for this condition? ☐Yes ☐No
If so, where?_____

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REFERRAL

Referred by:
Friend:_____ (Name of friend who referred you to us)
Employer:_____ (Name of Company)
Attorney:_____ (Name of Attorney)
Doctor:_____ (Name of Doctor)

Newspaper Television
Yellow Pages Radio
Billboards
Other:_____

4 four

please continue on back

PAIN CHART

ABOUT YOU

Name:_____ Date:___/___/___

Please describe your condition: _____

_____

_____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain). (*Circle*) **1 2 3 4 5 6 7 8 9 10**

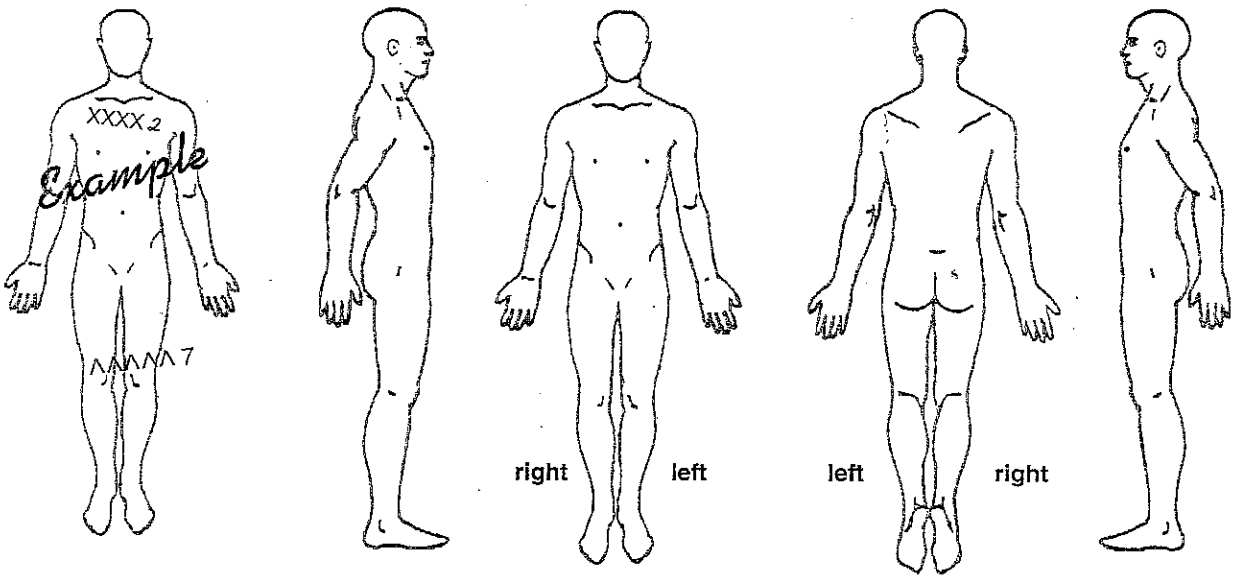
Frequency of pain: Intermittent (0-25% of the time) Occasional (26-50% of the time) Frequent (51-75% of the time) Constant (76-100% of the time)

Numbness or Tingling ooooo

Burning ^^^^

Sharp or Stabbing xxxxxxx

Aching ●●●●



Example Right Front Back Left

DOCTORS NOTES

_____

_____

_____

_____

_____

_____

_____

IF WORK /AUTO ACCIDENT
PLEASE CONTINUE ON BACK

5 five

HEALTH HISTORY

Are you taking any of the following medications?

☐Pain killers ☐Muscle relaxers ☐Nerve pills ☐Insulin ☐Stimulants
☐Blood pressure ☐Stimulants ☐Tranquilizers ☐Other(s)_____

Have you ever had any of the following diseases/medical condition(s)?

☐Heart Attack/Stroke	☐Heart Surg./Pacemaker	☐Heart Murmur
☐Congenital Heart Defect	☐Mitral Valve Prolapse	☐Artificial Valves
☐Alcohol/Drug Abuse	☐Venereal Disease	☐Hepatitis
☐HIV+/Aids	☐Shingles	☐Cancer
☐Frequent Neck Pain	☐Emphysema/Glaucoma	☐Anemia
☐High/Low Blood Pressure	☐Psychiatric Problems	☐Rheumatic Fever
☐Severe/Frequent Headaches	☐Kidney Problems	☐Ulcers/Colitis
☐Fainting/Seizures/Epilepsy	☐Sinus Problems	☐Asthma
☐Diabetes/Tuberculosis	☐Difficulty Breathing	☐Chemotherapy
☐Lower Back Problems	☐Artificial Bones/Joints	☐Arthritis

Please list any other serious medical condition(s) you have or ever had:_____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Do you smoke? ☐No ☐Yes / How much?_____ How long?_____
Are you wearing: ☐Heel lifts ☐Sole lifts ☐Inner soles ☐Arch supports
What is the age of your mattress?_____ Is it comfortable? ☐Yes ☐No
For women: Are you taking Birth Control? ☐Yes ☐No
Are you Pregnant? ☐No ☐Yes/How long? _____ Nursing? ☐Yes ☐No

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ACCOUNT INFO

Person responsible for account

Name:_____
Relation:_____
Billing Address:_____
_____
City St. Zip
SS#:_____
DL#:_____
Wk Phone#:_____
Friend/Relative:_____
Phone:_____
Address:_____
_____

Payment Method:
☐Cash ☐Check ☐Credit Card
CC# (if accepted)_____
Expiration Date:___/____

- We invite you to discuss with us any questions regarding our services. The best health 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 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 any 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 hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered .
- 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 in my medical status.

Signature_____ Date ___/___/____

AUTO / WORK RELATED ACCIDENT

ABOUT YOU

Name:_____ Date:___/___/___

1 one

WORK RELATED ACCIDENT

Date & Time of Accident: ___/___/___ ☐a.m. ☐p.m.
Employer Name:_____ Phone #:_____
Employer Address:_____
_____
City State Zip

Did you report your accident to your employer? ☐Yes ☐No
Name of person reported to:_____
Has this type of accident happened to you before? ☐Yes ☐No
What part of body was injured?
☐Neck ☐Mid back ☐Low back ☐Other_____
Were you doing regular job at time of injury? ☐Yes ☐No
Describe the events that occurred just before and during your accident: _____
_____
_____
_____
_____

Have you seen any other doctor? ☐Yes ☐No
Name of Doctor:_____ ☐MD ☐DC
Was medication prescribed? ☐Yes ☐No
Have you been able to work since this injury ☐Yes ☐No
Is condition getting worse?
☐Yes ☐No ☐Constant ☐Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful *even if only sometimes*
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Working	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

2 two

AUTO RELATED ACCIDENT

Date of Accident: ___/___/___
☐Driver ☐Front Passenger ☐Rear passenger
Was a police report filed? ☐Yes ☐No
Were you wearing your seat belt? ☐Yes ☐No

Did any part of your body strike anything in the vehicle? ☐Yes ☐No
If yes indicate what part:
☐Head ☐Mid back ☐Shoulder(s) L/R
☐Arm(s) L/R ☐Leg(s) L/R ☐Chest
Hit against: ☐Door ☐Steering wheel
☐Seat ☐Dashboard
Did the impact to your vehicle come from the:
☐Front ☐Rear ☐Right side ☐Left side
Have you gone to a Hospital? ☐Yes ☐No
Name of Hospital:_____
Taken by: ☐Ambulance ☐Private Transportation
Name of Doctor:_____ ☐MD ☐DC
Was medication prescribed? ☐Yes ☐No
Is condition getting worse?
☐Yes ☐No ☐Constant ☐Comes & goes

Have you retained an attorney ☐Yes ☐No
If yes, Name:_____
His/Her Phone#_____