

PATIENT INFORMATION

Today's Date: _____

Patient: _____ Date of Birth: _____

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

SS No.: _____ Home Phone: _____ Work Phone: _____

E-Mail _____

Cell Phone: _____ Occupation: _____ Employer: _____

Marital Status: Married Single Widowed Divorced

Spouse: _____ SS No.: _____ Work Phone: _____

Occupation: _____ Employer: _____

Who referred you to our office? _____

PATIENT INSURANCE

Do you have medical insurance? Yes / No Did C.A. copy card? Yes / No

Who is responsible for payment? Self Spouse Other _____

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patients Signature _____

ADDITIONAL INFORMATION

Please list your current symptoms:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Date of illness or onset: _____ Time: _____ Location: _____

Related to accident? Auto _____ On the job _____ Other: _____

List any other Doctors seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? _____

If yes, please explain: _____

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical exam, X-Ray studies, Lab procedures, Chiropractic care or any clinic services that he/she deems necessary in my case: I further authorize him/her to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patients signature _____

Over Please

HEALTH QUESTIONNAIRE

Please check conditions you are currently experiencing or have experienced in the past.

MUSCULO-SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Muscle spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

NERVOUS SYSTEM

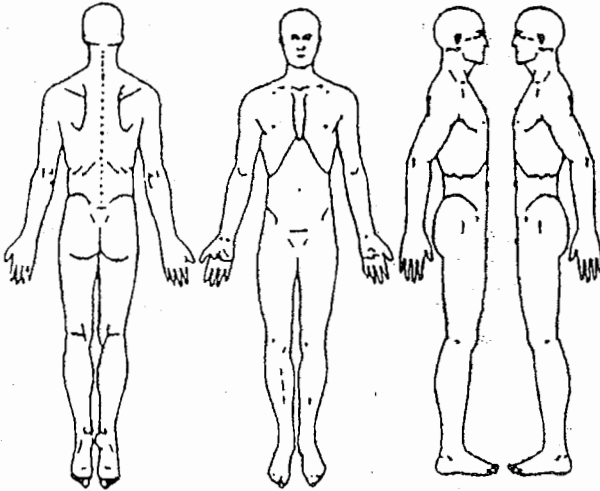
- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- _____

Patient's Signature _____

Please mark areas of pain on the figures below



Pain Index

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

FOR OFFICE USE

Services: _____
