

Patient Name _____ Date _____

Address _____

Provide your phone numbers (Check the best phone number to reach you at):

- Home phone # _____
- Cell phone # _____
- Work phone # _____

E-mail _____

In case of emergency, contact: _____ phone _____

Sex: M F Age _____ Birthdate _____

- Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Spouse's Birthdate _____ Spouse's SS# _____

Spouse's Occupation _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Are you in pain: Yes No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense Pain

Did your injury occur during: Work Sports/ play Auto Accident Routine/ Household activity

When did your condition/ accident occur? _____/_____/_____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes

Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Has this or something similar happened in the past?
 Yes No Explain: _____

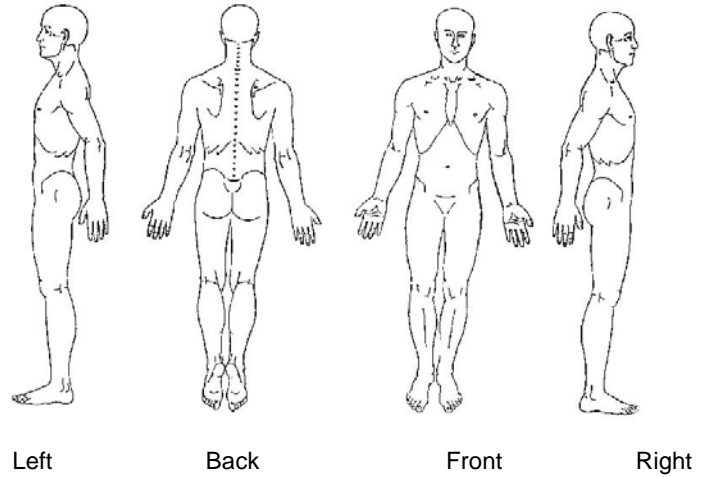
Using the adjacent body charts, please circle all affected Areas.

Have you been treated by a medical physician for this Pain? Yes No If so, where? _____

Have you ever been treated by a chiropractor? Yes No

Clinic or Dr's Name: _____

Clinic Phone#: _____



Are you taking any of the following medications? Nerve Pills Pain killers (including aspirin) Muscle relaxes Blood thinners

Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|------------------------|--------------------|------------------------|--------------------------|----------------------|
| Y N AIDS/HIV | Y N Epilepsy | Y N Kidney Disease | Y N Pinched Nerve | Y N Stroke |
| Y N Alcohol/Drug Abuse | Y N Eye Problems | Y N Liver Disease | Y N Prostate Problem | Y N Thyroid Problems |
| Y N Arthritis | Y N Gout | Y N Migraine Headaches | Y N Psychiatric Care | Y N Tuberculosis |
| Y N Asthma | Y N Heart Disease | Y N Multiple Sclerosis | Y N Rheumatoid Arthritis | Y N Tumors/Growths |
| Y N Cancer | Y N Hepatitis | Y N Osteoporosis | Y N Shingles | Y N Ulcers |
| Y N Diabetes | Y N Herniated Disk | Y N Pacemaker | Y N Sinus Problems | Y N Venereal Disease |

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

Please list anything that you may be allergic to:

Family Health History:

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How Long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since ____/____/____

For Women: Are you taking Birth Control? Yes No

Are you nursing? Yes No Are you pregnant? Yes No If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best 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 legal fees, collection agency fees, interest charges and any other 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 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 to the information I have provided.

Signature _____ Date ____/____/____

Adult patient Parent or Guardian Spouse