



Today's Date: ___/___/___

Patient Name: _____ Name you preferred to be called?: _____

Birth date: ___/___/___ Age: ___ Male Female E-Mail Address: _____

Mailing Address: _____ City, State, Zip: _____
(STUDENTS- please put your local address here)

Home Phone #: _____ Work Phone #: _____ Other Phone #: _____

Employer: _____ Employer's Address: _____

Referred by: _____ Do you have children? No Yes How Many: _____

Status: Minor Single Married Divorced Separated Widowed Spouse's Name: _____

Account Information

Person ultimately responsible for account:

Name: _____ Relation: _____ Work Phone: _____

Billing Address: _____ City, State, Zip: _____
(STUDENTS- put your parent's address here, if appropriate for billing)

SSN: _____ D.L #: _____ Payment Method: Cash Check Credit

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company if offered at this office.

1. Is today's problem caused by:

- Auto Accident Workman's Compensation Neither

2. What is your main area of complaint? _____

3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your condition?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

If you saw a doctor or therapist, please list their name here: _____

IN THE EVENT OF EMERGENCY

Who should we contact?

Relationship to you:

Phone: _____

Other #: _____

Who is your Medical Doctor?

Medical Doctor's phone #: _____

FOR OFFICE USE ONLY

Pt file #: _____

BP: _____

Pulse: _____

Patient Name: _____

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe?
 Yes Yes, at times No Bothersome

13. What aggravates your condition? _____

14. What concerns you the most about your problem; what does it prevent you from doing? _____

15. What is your: Height _____ Weight _____ Occupation _____

16. How would you rate your overall Health?
 Excellent Very Good Good Fair Poor

17. What type of exercise do you do?
 Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:
 Rheumatoid Arthritis Diabetes Lupus None
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

PAST PRESENT

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip Pain
- Upper Leg Pain
- Knee Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Pain/Stiffness
- Arthritis
- Rheumatoid Arthritis
- Cancer
- Tumor
- Asthma
- Chronic Sinusitis
- Other: _____

PAST PRESENT

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder
- General Fatigue
- Muscular In-coordination
- Visual Disturbances
- Dizziness

PAST PRESENT

- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Tobacco Use
- Drug/Alcohol Dependence
- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV / AIDS

<u>For Females Only</u>	
<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Pregnancy

Doctor's Notes:

20. List all prescription medications you are currently taking: (If you have a list, we can copy it): _____

21. List all of the over-the-counter medications & vitamins you are currently taking: _____

22. List all surgical procedures you have had and approximate dates: _____

Patient Name: _____

23. What activities do you do at work or at home?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work? Activities or hobbies: _____

25. Have you ever been hospitalized? No Yes If yes, why _____

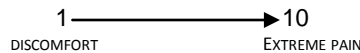
26. Have you seen a Chiropractor before? No Yes If yes, how long ago? _____
How were your results? Great Good Fair Mixed Poor Other _____

27. Have you had significant past trauma? No Yes _____

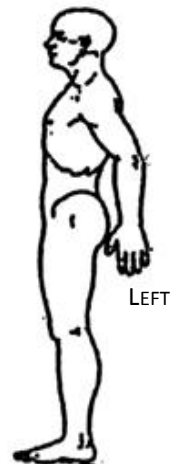
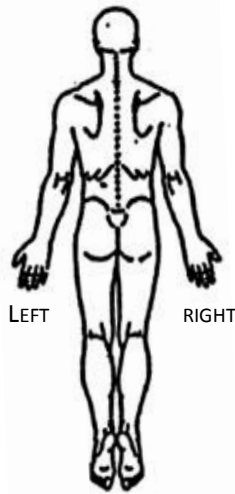
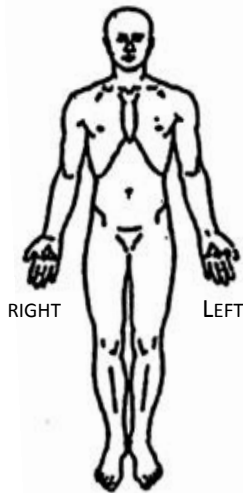
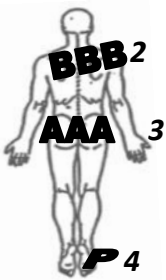
28. Please mark area(s) of injury or discomfort using

A) Letters to describe your pain B) Numbers for the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

- N = Numbing
- P = Pins & Needles
- B = Burning
- A = Aching
- S = Stabbing



EXAMPLE:



29. Anything else pertinent to your visit today? _____

- 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 requests 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, 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 and or managed care organization, to release any information required to process insurance claims.

Patient Signature _____ **Date:** _____

Thank you so much for taking the time to complete this form.
This form will help the doctor to better serve you with your health care needs.