

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. (Please Print)

Name _____ S/S _____ - _____ - _____ Date _____
Address _____ City _____ State _____ Zip _____
Sex (circle) Female Male Date of Birth ____/____/____
Home phone # (____) _____ Work # (____) _____ Email address: _____
I am: (circle one) a minor Married Divorced Widowed Single Separated
Your Employer _____ Occupation _____
Business Add _____ City _____ State _____ Zip _____
Spouse or Parent's name _____ Employer _____ Phone _____
Person to contact in case of emergency _____ Phone # (____) _____
Who referred you? _____

INSURANCE INFORMATION

Primary - (present card to receptionist)

Insurance _____ Primary Insured Name _____
Policy #/ SS# _____ Date of Birth ____/____/____

Secondary - (present card to receptionist)

Insurance _____ Primary Insured Name _____
Policy #/ SS# _____ Date of Birth ____/____/____

CHIROPRACTIC TREATMENT CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interests, based upon the facts as they are then known.

X _____

Signature of Patient (or parent if a minor)

_____/_____/____

Date

AUTHORIZATION/FINANCIAL RESPONSIBILITY

I authorize the chiropractor to release any information concerning my diagnosis and medical records about any treatment or examination rendered to me or my child during the period of chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the chiropractor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that payment for services and/or the applicable copayment is due at the time of service.

X _____

Signature of Patient (or parent if a minor)

_____/_____/____

Date

CURRENT CONDITION

What are your objectives in visiting the chiropractor?

If you are here due to pain, please describe what you were doing when the pain first occurred.

Describe what your pain feels like.

What do you do to relieve the pain? _____

Please list any major accidents, falls or injuries within the approximate date.

How do the following activities change your pain and what duration of time can you tolerate each activity?

	No Change	Relieves	Increased	Duration
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10, rate the severity of your pain. If your pain fluctuates please mark both and indicate approximately the % of time at each level Example 0 1 2 3 4 5 6 7 8 9 10

	70%							30%			
	No Pain							Severe Pain			
	0	1	2	3	4	5	6	7	8	9	10
Neck Pain											
Mid Back Pain											
Low Back Pain											
Other											

If you have ever visited a chiropractor or chiropractors in the past, please list:

What did you like or not like about your previous treatment experiences?

Mark the areas on this body where you feel pain. Use the appropriate symbols.

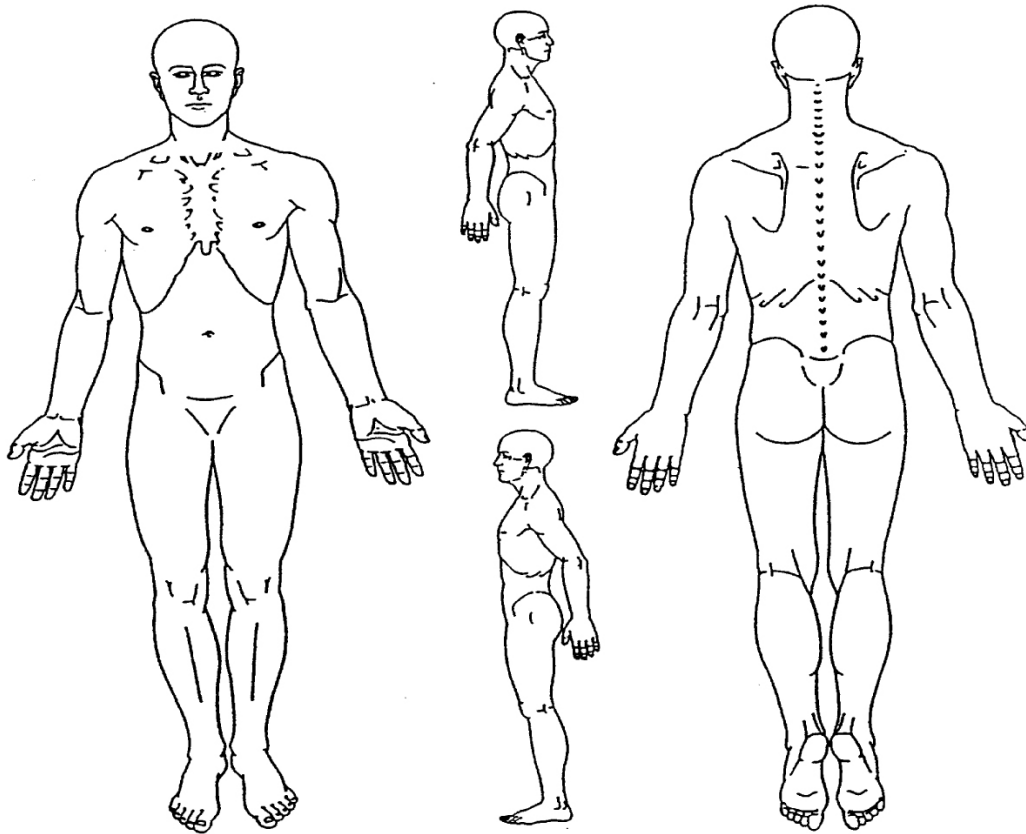
KEY:

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE
N = NUMBING

B = BURNING
P = PINS & NEEDLES

C = STABBING
O = OTHER



Please give approximate date of last:

Spinal Exam _____ Physical Exam _____

Spinal X-Ray _____ Other Spinal Imaging _____