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_____ Date_____
Address_____ City_____ State_____ Zip_____
Sex (circle) Female Male Date of Birth____/____/____ Height_____ Weight _____
Home phone # (_____) _____ Cell # (_____) _____ Email:_____
I am: (circle one) a minor Married Divorced Widowed Single Separated
Your Employer _____ Occupation _____
Business Address _____ 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 co-payment is due at the time of services.

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	[ ]	[ ]	[ ]	_____
Looking up	[ ]	[ ]	[ ]	_____
Walking	[ ]	[ ]	[ ]	_____
Looking Down	[ ]	[ ]	[ ]	_____
Standing	[ ]	[ ]	[ ]	_____
Turning	[ ]	[ ]	[ ]	_____
Lying Down	[ ]	[ ]	[ ]	_____
Bending	[ ]	[ ]	[ ]	_____
Lifting	[ ]	[ ]	[ ]	_____

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
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

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

_____

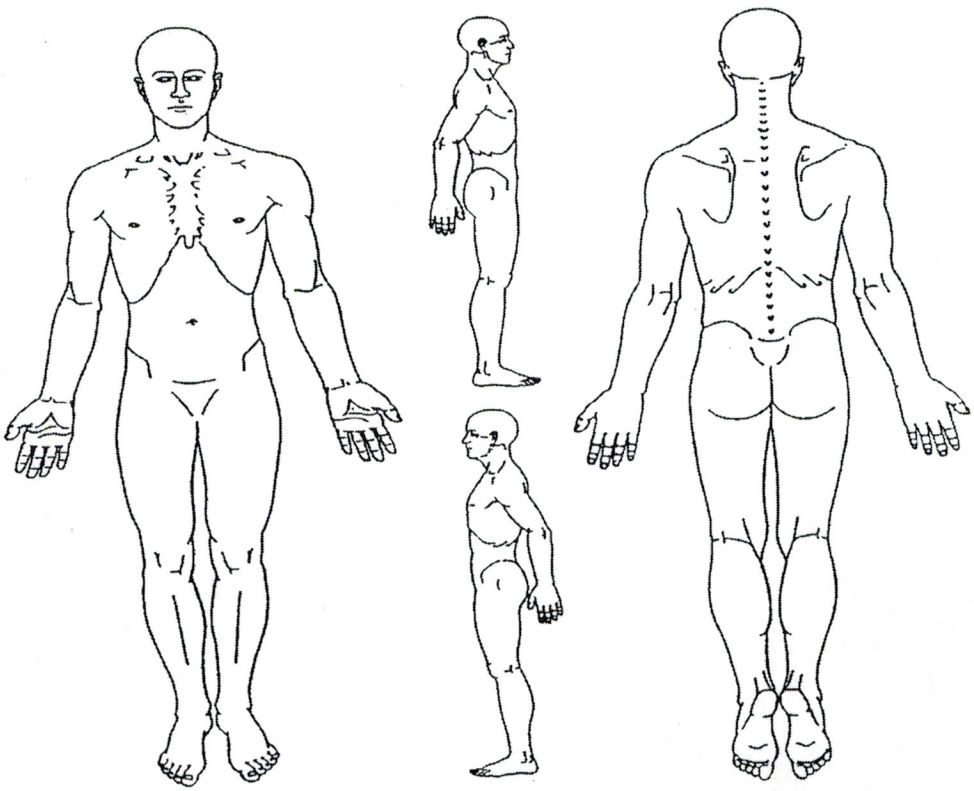
What did you like or not like about your previous treatment experiences?

_____

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 **B = BURNING** **C = STABBING**
N = NUMBING **P = PINS & NEEDLES** **O = OTHER**



Please give approximate date of last:
Spinal Exam _____ Physical Exam_____
Spinal X-Ray _____ Other Spinal Imaging _____