

CONFIDENTIAL PATIENT INFORMATION

Please Print

Patient Information

Full Name:_____ Date of Birth_____ Age____ Male Female
Address:_____ City:_____ State:____ Zip:_____

Home Phone: (____)_____ Alternate Phone: (____)_____ SS#:____ - ____ - _____

Email Address:_____ Date of last menstrual cycle : ____/____/____

Marital Status: Single Married Widowed How did you hear about us?_____

Parent/Guardian Name:_____ Relationship to Patient:_____

Patient Status: Employed Student Retired Disabled

Employers Name:_____ Occupation:_____

Employer Address:_____ City:_____ State:____ Zip:_____

Emergency Contact:_____ Phone: (____)_____

Insurance Information

Insured's Name:_____ Insured's Date of Birth:_____

Patient's Relationship to Insured: Self Spouse Child Other

Insured's Employer:_____ Insured's SS#:____ - ____ - _____

Authorizations

1. I hereby authorize release of any medical information to process this claim and request payment of insurance benefits to the party who accepts assignment.
2. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
3. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 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 understand that if I suspend or terminate care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature:_____ Date: ____/____/____

Guardian's Signature:_____ Date: ____/____/____

HEALTH INFORMATION

Patient Name: _____ Date: _____

1. Have you ever received Chiropractic Care: Yes No If Yes, When: _____

2. Reason for receiving chiropractic care:

Primary complaint: _____

When did this begin?: _____ How did this begin?: _____

Secondary complaint: _____

When did this begin?: _____ How did this begin?: _____

3. Please circle the Quality of the complaint/pain:

Burning Dull Sharp Shooting Aching Throbbing Other: _____

4. Rate this complaint: Mild Moderate Severe

5. Does this complaint/pain radiate or travel (shoot) to any areas of your body? No Yes

Where: _____

6. Do you have any numbness or tingling in your body? No Yes Where?: _____

7. Grade Intensity/Severity: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

8. How frequent is complaint present?: Occasional Intermittent Frequent Constant

9. Does anything make the complaint better?: (circle all that apply)

Nothing Rest Sitting Stretching Exercise Standing Heat Ice Medications Other: _____

10. Does anything aggravate the complaint?: (Circle all that apply)

Nothing Sneezing Bending Coughing Lifting Walking Reaching Sitting Straining at Stool
Standing Pulling Turning Other: _____

11. Please circle when your symptoms are worse: Morning Afternoon Evening Night Always the Same

12. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

13. Do you have any other complaints not covered in primary or secondary complaint?: No Yes

If yes, Explain: _____