PATIENT INTRODUCTION

Date_____ Name_____Sex_____

Home Phone #_____ Cell #_____

Address_____ City _____

State_____ Zip_____-_____ Date of Birth _____/_____/_____

E-Mail Address_____ Social Sec. #_____-_____-_____

Employed By _____phone #_____

Business Address_____

Spouses Name (or **insured parent if a minor**) _____

Date of Birth_____/_____/_____ Cell #_____Social Sec. # _____

Employed By_____ phone #_____

Business Address_____

Who do we contact in case of Emergency_____ Phone #_____

Person Responsible for Account (check one) _____self _____ parent

Primary Insurance Company_____

Secondary Insurance Company_____

Our office policy requires payment in full for all services at the time of visit UNLESS other arrangements are made with office manager. If the account is not paid in full within 90 days of the date of service, and no financial arrangement has been made, you will be responsible for any expense incurred to collect your account. If you need to make financial arrangements, inform the staff.

I hereby authorize payment of medical benefits directly to this physician of any benefits due me for services rendered by this office. I further authorize this office to release any information required to process insurance claims on my behalf. I understand and agree to the policies of this office and attest that the information I have provided is true and correct to the best of my knowledge.

It is my responsibility to inform the office to any changes in my personal or insurance information.

Signature of Person Responsible_____ Date _____

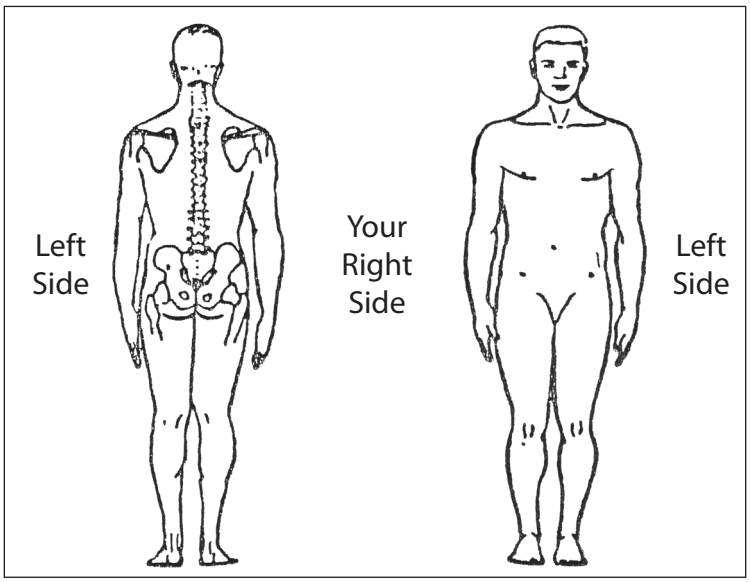
Name_____ Sex M F Age _____ Usual Work Hours _____

How did you come to choose our office? _____

What problem(s) brought you to our office? _____

_____

Color areas of your pain with marker



Rank your problems–1 being the most bothersome

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Your Primary Problem (Circle Appropriate Answer)

- O when did it start_____
- P what helps it _____
- P what makes it worse _____
- Q is it---sharp, dull, throbbing, numb, tingling, Other_____
- R does pain radiate or stay local
- S does it bother you – am, pm, night, or anytime
- S rate pain mild 1 2 3 4 5 6 7 8 9 10 severe
- T constant frequent intermittent occasional

Is it getting worse staying the same getting better

How is the pain affecting your work, sleep, and daily activies?

_____

_____

Have you seen anyone else for this problem?_____

_____

Your Secondary Problem (Circle Appropriate Answer)

- O when did it start_____
- P what helps it _____
- P what makes it worse _____
- Q is it---sharp, dull, throbbing, numb, tingling, Other_____
- R does pain radiate or stay local
- S does it bother you – am, pm, night, or anytime
- S rate pain mild 1 2 3 4 5 6 7 8 9 10 severe
- T constant frequent intermittent occasional

Is it getting worse staying the same getting better

How is the pain affecting your work, sleep, and daily activies?

_____

_____

Have you seen anyone else for this problem?_____

_____

Name of previous chiropractor _____ Was it helpful? _____

Dr.'s Notes _____

_____

Please circle any areas you have pain in.		
Low Back	Hip	Foot
Neck	Knee	Elbow
Between Shoulders	Shoulder	Hand

Please circle any other health issues.				
Arthritis	T.M.J.	Sinus/Allergy	Diarrhea	High Blood Pressure
Tendonitis	Headaches	Asthma	Menstrual Cramps	Other_____
Bursitis	Migraines	Heartburn	Fatigue	_____
Carpal Tunnel	Dizziness	Constipation	Diabetes	_____

Have you ever had a stroke? _____ T.I.A.? _____ Aneurism? _____ Cancer? _____

Who is your Medical Doctor? _____ Do you exercise? _____ How often? _____

Do you use tobacco? Type and frequency _____ Do you take supplements? _____

List supplements _____

How often do you have more than 3 alcoholic drinks in a day? Frequently Occasionally Rarely Never

How many glasses of water do you drink a day? _____ # soft drinks a day? _____ # of caffeinated drinks a day _____

Do you eat enough fruits? _____ Do you eat enough vegetables? _____

Hours of sleep a night? _____ Your weight? _____ Your height? _____

Do you feel you are at a proper weight? _____ Are you trying to lose weight? _____

Do you get headaches? _____ How often? _____ How severe? _____

List surgeries _____

List any other hospitalizations _____

Any auto accident injuries? _____

Other injuries _____

Are you allergic to anything? _____

What conditions do you medicate for? _____

_____

Notice any side effects? _____

How would you rate your health Excellent Good Fair Poor Any desire to improve it? _____

Do parents or siblings have Cancer? _____ Heart Problems? _____ High Blood Pressure? _____ Diabetes? _____

Please give details _____

I agree to have the doctor examine me. I will have the option to undergo recommended diagnostic test and/or treatment as the doctor prescribes. I understand that the doctor only accepts patients we feel may be helped, and though most patients respond well to treatment, we cannot guarantee results, as every person is different, with unique physiology.

Signature _____ Date _____

_____

_____

_____