Patient Information Doctor _____

Legal First Name: _____ MI: ____ Last Name: _____ Male /Female

Street: _____ Apt: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Marital Status: S M W D Spouse: _____

Primary Language: □ English □ Other: _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino
□ Native Hawaiian/Other Pacific Islander □ White □ Decline to answer □ Other _____

Ancestor's Country of Origin: _____

DOB: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Carrier _____

E-mail home: _____ E-mail work: _____

Please check your contact preference: □Hm Phn □Wk Phn □Cell □Hm Email □Wk Email □Postal Mail

Occupation: _____ Employer Name and address _____

What health insurance do you want us to bill for you? _____

Whom may we thank for referring you to our office? _____

Emergency Contact: _____ Phone Number: _____

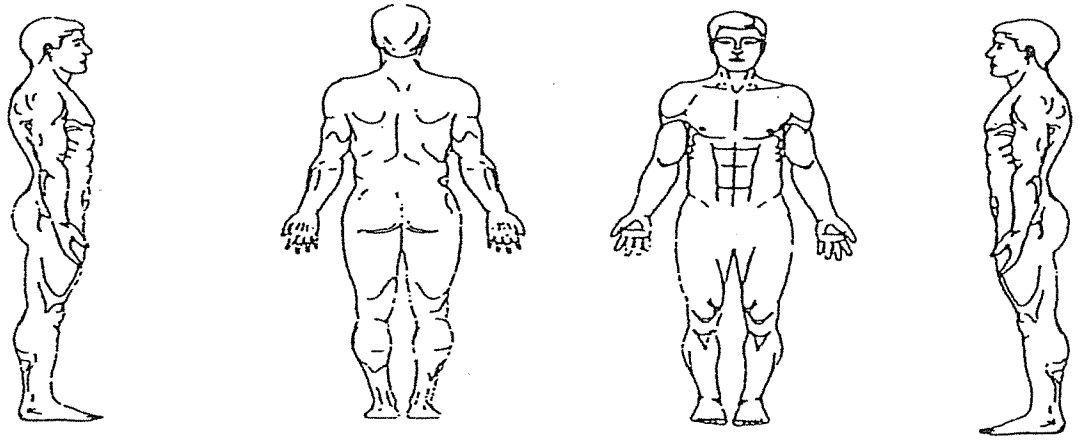
Health History

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN: _____

_____

DATE PROBLEM BEGAN: _____

Mark an X on the picture where you have pain or other symptoms



Rate your pain:	1	2	3	4	5	6	7	8	9	10
Descriptor:		Mild		Slight		Moderate		Moderate-Severe		Severe
Functionally:		Annoyance & can be ignored		Interferes with tasks		Very difficult to perform tasks		Prohibits most tasks		Bedridden- Worst imaginable pain

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you have this pain? (Please check one) □ 0 – 25% □ 26 – 50% □ 51 – 75% □ 76 - 100%

Is it constant or does it come and go? _____

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation?

Activities which are painful to perform? □Sit □Stand □Walk □Bend □Lying Down □Other_____

What treatment have you previously received for your condition? □Medications □Surgery □Physical Therapy

□Chiropractic Services □None □Other _____

Is this condition due to an accident? □No □Yes - Type of Accident: □Auto □Work □Home □Other_____

Patient History

Are you being treated for other problems or health conditions? □Yes □No

Please list the problem	Date problem began	Provider treating you for the condition:

Height: _____Feet _____Inches Weight: _____lbs Recent Blood Pressure if known _____/_____mm Hg

Do you smoke? □ Never □ Former Smoker □ Current/Every Day Smoker □ Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...
Please be as specific as possible

Date Started	Brand Name	Generic Name	Strength	Dosage / Frequency	Duration / Quantity	Prescribed by

Do you have allergies? (If no, write "None")

	List	Reaction
□ Food		
□ Environmental		
□ Medication		

Please mark Yes or No to indicate if you have had any of the following:

AIDS/HIV	□Yes □No	Emphysema	□Yes □No	Mononucleosis	□Yes □No
Alcoholism	□Yes □No	Epilepsy	□Yes □No	Multiple Sclerosis	□Yes □No
Anemia	□Yes □No	Fractures	□Yes □No	Mumps	□Yes □No
Anorexia/Bulimia	□Yes □No	Glaucoma	□Yes □No	Osteoporosis	□Yes □No
Appendicitis	□Yes □No	Gout	□Yes □No	Pacemaker	□Yes □No
Arthritis	□Yes □No	Headaches	□Yes □No	Parkinson's Disease	□Yes □No
Asthma	□Yes □No	Heart Disease	□Yes □No	Prostate Problems	□Yes □No
Bleeding Disorders	□Yes □No	Hernia	□Yes □No	Psychiatric	□Yes □No
Bronchitis/Pneumonia	□Yes □No	Herniated Disk	□Yes □No	STD	□Yes □No
Cancer/Tumors	□Yes □No	High Blood Pressure	□Yes □No	Stroke	□Yes □No
Cataracts	□Yes □No	High Cholesterol	□Yes □No	Thyroid Problems	□Yes □No
Chemical Dependency	□Yes □No	Kidney Disease	□Yes □No	Tuberculosis	□Yes □No
Chicken Pox	□Yes □No	Liver Problems	□Yes □No	Ulcers	□Yes □No
Diabetes	□Yes □No	Miscarriages	□Yes □No	Whooping Cough	□Yes □No

Family Health History

Use the following code to represent Family Member:
M=Mother, F=Father, B=Brother, S=Sister, MG=Maternal Grandparent, PG=Paternal Grandparent, C=Child

Condition	List Family Member Code	Living/Deceased Circle	If Deceased, what was cause of death
Cancer	(Example) M; PG	L / (D)	M-Heart Disease; PG-Cancer
Cancer		L / D	
Diabetes		L / D	
Heart Disease		L / D	
Heart Failure		L / D	
High Blood Pressure		L / D	
Kidney Disease		L / D	
Stroke		L / D	

□ None/Unknown

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement 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 doctor's 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 and agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____

Date_____