PATIENT INTRODUCTION

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. PLEASE PRINT.

PATIENT:_____ HOME PHONE: ( )_____

WORK PHONE: ( )_____

HOME ADDRESS :_____
(Street - City - State - Zip)

MALE:__ FEMALE:__ SINGLE:__ MARRIED:__ EMAIL _____

SOCIAL SECURITY #:_____ DATE OF BIRTH:_____ AGE: _____

VISA / MC# :_____ EXPIRATION DATE: _____
(Optional)

EMPLOYER'S NAME: _____ OCCUPATION: _____

SPOUSE'S NAME:_____ OCCUPATION:_____

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S SOCIAL SECURITY # : _____

SPOUSE'S EMPLOYER :_____ SPOUSE'S BUSINESS PHONE #: _____

IN CASE OF EMERGENCY NOTIFY:_____
(Name - phone number - relationship)

WHO REFERRED YOU TO THIS OFFICE?(Full Name): _____

INSURANCE INFORMATION-

1st INSURANCE COMPANY: _____ PHONE # : _____

GROUP NUMBER: _____ POLICY NUMBER: _____

2nd INSURANCE COMPANY:_____ PHONE #: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

TYPE OF INSURANCE: __GROUP __PRIVATE __ AUTO __ WORKER'S COMP. __ OTHER

HAVE YOU MET YOUR DEDUCTIBLE THIS YEAR? __ YES __ NO

NAME OF THE INSURED IF DIFFERENT THAN ABOVE : _____

SOCIAL SEC. #:_____ DATE OF BIRTH:_____ RELATIONSHIP_____

PURPOSE OF THIS APPOINTMENT: _____

_____

ARE YOUR PROBLEMS DUE TO AN INJURY? ___ YES ___ NO

___ AUTO ACCIDENT ___ WORK INJURY ___ OTHER: _____

DATE OF INJURY OR ILLNESS? _____ HOUR: _____ AM/PM

WHAT STANDING / SITTING / LYING POSITION OR ACTIVITIES AGGRAVATE YOUR CONDITION: _____

_____

DOES YOUR PAIN WAKE YOU UP AT NIGHT? ___ YES ___NO NIGHT SWEATS: ___ YES ___ NO

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION?: ___ YES ___ NO NAME: _____

PRESCRIBED TREATMENT: _____

MEDICATIONS TAKEN PRESENTLY: _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A DOCTOR IN THE LAST YEAR ?: ___ YES ___ NO

IF YES, EXPLAIN: _____

PREVIOUS ACCIDENTS / INJURIES: _____

PREVIOUS SURGERIES: _____

PLACE AN "X" NEXT TO THE ITEM YOU SUFFER OR HAVE SUFFERED FROM:

HEAD AND NECK

___ HEADACHES
___ HEAD INJURIES
___ FAINTING SPELLS
___ DIZZY SPELLS
___ SEIZURES
___ JAW PAIN
___ DEPRESSION
___ DIFFICULTY SWALLOWING

NERVOUS-MUSCULAR-SKELETAL SYSTEM

___ ARTHRITIS
___ BROKEN BONES, WHERE: _____
___ NECK PROBLEMS
___ PAIN BETWEEN SHOULDERS
___ LOW BACK PROBLEMS
___ SHOULDER, ELBOW, HAND PROBLEMS
___ HIP, KNEE, FOOT PROBLEMS
___ MUSCLE STIFFNESS
___ SORE MUSCLES
___ WEAK MUSCLES
___ MUSCLE SPASMS
___ GOUT
___ PARALYSIS
___ NUMBNESS
___ TINGLING
___ NERVOUSNESS

CIRCULATORY SYSTEM

___ ANEMIA
___ VARICOSE VEINS
___ CHEST PAIN
___ HIGH BLOOD PRESSURE
___ HEART DISEASE
___ RAPID HEART RATE
___ ARTERIOSCLEROSIS
___ STROKE

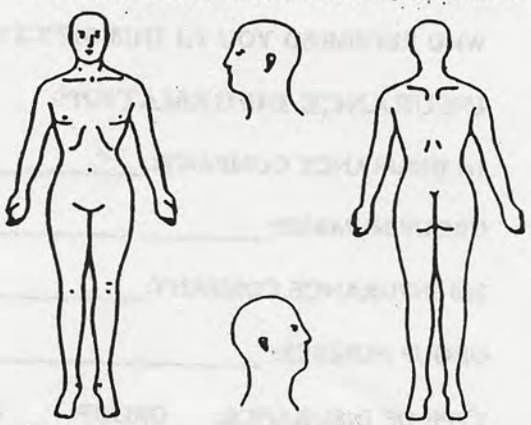
DIGESTIVE SYSTEM

___ ABDOMINAL PAIN
___ CONSTIPATION
___ DIARRHEA
___ HEARTBURN
___ NAUSEA
___ EXCESSIVE WEIGHT GAIN
___ EXCESSIVE WEIGHT LOSS
___ ULCERS
___ GAS

RESPIRATORY SYSTEM

___ ASTHMA
___ EMPHYSEMA
___ PERSISTANT COUGH
___ PAIN WHEN BREATHING
___ DIFFICULTY BREATHING
___ LUNG DISEASE

Draw in your areas of pain on the figures below.



I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE AND FORWARD ALL NECESSARY CLAIM FORMS AND REPORTS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT ON 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 ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE DEEMS APPROPRIATE THOUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT OR GUARDIAN
SIGNATURE AUTHORIZING CARE: