WELCOME

Thank you for presenting to our office today.
Evaluation Intake Form for Wharfside Chiropractic Center

Today's Date: _____

Patient Name: _____ Male ___ Female ___
LAST FIRST MI
What do you prefer to be called? _____

Birthdate: ____/____/_____ Age: _____ SS#: _____

Mailing Address: _____
_____

Home Phone: _____ Work Phone: _____ Cell: _____
Email Address: _____
Referred by: _____
Employer: _____
Employer's Address: _____
Occupation: _____
Status: Minor___ Single ___ Married ____ Divorced ___ Separated __ Widowed ____
Spouses Name: _____Do you have children? Yes __ No __ How many? __

REASON FOR VISIT:
The reason for today's visit is a result of an injury while performing work related activities. Please explain in detail how injury occurred:

a. Date and time of accident: _____
b. What were you doing at time of injury? _____
_____
_____
c. Were there any witnesses? _____

Please describe how you were feeling immediately prior to accident: _____
_____
Please describe how you felt immediately after the accident: _____
_____
_____

Have you gone to a Hospital or seen any other doctor? Yes ___ No ___
When did you go? Just after accident ___ Next day ____ 2 days plus _____
How did you get there? Ambulance ___ Someone else ___ Self _____
Name of Hospital and/or attending physician: _____
Was he a D.C. ____ M.D. ____ D.O. ____ D.D.S. ___ Other: ____
Describe any treatment you have received: _____
_____
_____

Were X-rays or other pictures(MRI, CT, etc) taken? Yes ___ No ___ If yes, are you aware of the Results? _____
Any medication been prescribed? _____ Are you taking any medication now? Is so, please list.

_____

If you were working, have you returned? Yes ___ No ___

Please indicate any symptoms that you feel might be a result of this accident:

Dizziness __ *Difficulty Sleeping*___ *Jaw Problems* __ *Nausea* ___ *Memory Loss* ___ *Irritability* ___
Arms/Shoulder Pain ___ *Back pain* ___ *Headache* ___ *Fatigue* ___ *Numb Hands/Fingers* ___
Lower Back Pain ___ *Blurred Vision* ___ *Tension* ___ *Chest Pain* ___ *Back Stiffness* ___ *Buzzing in ear* ___
Neck Pain ___ *Shortness of Breath* ___ *Leg pain* ___ *Ears Ringing* ___ *Neck Stiffness* ___ *Upset Stomach* ___
Numb Feet/Toes *Other*

_____

Please list any and all activities that you feel have become painful or uncomfortable to perform (i.e.: lifting, bending, sitting, driving, etc..): _____

_____

Has your condition changed since your injury/accident? Yes ___ No ____
Please describe _____

Do you feel your condition is getting worse? Yes ____ No ___

Have you had this or similar conditions in the past? Yes ___ No ___

Have you ever had any surgeries or been told you have a (any) serious or significant medical condition? If yes, please list:

_____

_____

_____

Have you retained an attorney? Yes__ No ___ If yes, whom: _____

Are you presently taking any vitamins or supplements? Yes ___ No ___
If yes, please list. _____

FOR WOMEN: Are you taking Birth Control? Yes ___ No ____
Is there any way you might be pregnant? Yes ___ No ___ Possibly ___
Are you Nursing? Yes __ No ____

ACCOUNT INFORMATION:
Person ultimately responsible for account? _____
Relation: _____ Billing Address _____

_____

SS#: _____
Payment Method: Employer: _____ Cash _____ Check ____ Credit card ____
Other _____
If using a third party (Insurance, etc) for any portion of your services with our office please initial that you hereby authorize assignment of my insurance rights and benefits

directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company or any other third party utilized for assignment of benefits. Initial _____

ADDITIONAL INSURNCE

2ND Insurance Source

Type of Insurance _____ Co. Name: _____ Insured's Name: _____

Address of Insurance: _____

Phone #: _____ Policy #: _____

Thank you for taking the time to complete our questionnaire form to assist our Doctor with your Consultation today.

_____

Patient Signature