

# Welcome

## PATIENT INFORMATION

Date: \_\_\_\_\_  
Patient (PLEASE PRINT) \_\_\_\_\_  
Address: \_\_\_\_\_  
CITY STATE ZIP  
E-mail: \_\_\_\_\_  
Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
Number of Children: \_\_\_\_\_  
Patient S.S. #: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Employer Telephone: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_  
  
Whom may we thank for referring you? \_\_\_\_\_  
\_\_\_\_\_

## TELEPHONE NUMBERS

Home: \_\_\_\_\_ Work: \_\_\_\_\_ ext \_\_\_\_\_  
Cell: \_\_\_\_\_ Other: \_\_\_\_\_  
Best time & place to contact you \_\_\_\_\_  
  
In Case of Emergency, Contact:  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ ext \_\_\_\_\_  
Cell: \_\_\_\_\_ Other: \_\_\_\_\_

## INSURANCE INFORMATION

Who is responsible for this account: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Have you met your deductible?  Y  N  
Is Patient covered by additional insurance?  Y  N  
Subscriber: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ S.S.#: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Group #: \_\_\_\_\_

### Assignment and Release:

I, the undersigned, do certify that I (or my dependant) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship to Patient

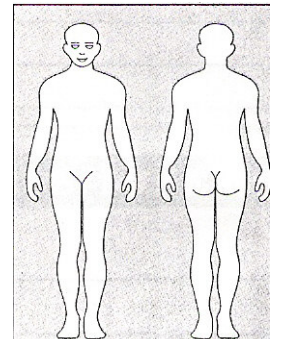
\_\_\_\_\_  
Date

## ACCIDENT INFORMATION

Is condition due to an accident?  Y  N  
Date of Accident: \_\_\_\_\_  
Type of accident:  Auto  Work  Home  Other  
To whom did you report the accident?  
 Auto Insurance  Employer  Work Comp  
 Other: \_\_\_\_\_  
Attorney Name (if applicable) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PATIENT CONDITION

Reason for visit: \_\_\_\_\_  
  
When did your symptoms first appear? \_\_\_\_\_  
Is this condition getting progressively worse?  Y  N  Unknown  
Mark an **X** on the picture where you continue to have pain, numbness, or tingling  
Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain): \_\_\_\_\_  
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other (please describe) \_\_\_\_\_  
  
How often do you have this pain? \_\_\_\_\_  
Is it constant, or does it come and go? \_\_\_\_\_



Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying down

What treatments have you already received for this condition?  Medication  Surgery  Physical Therapy

Chiropractic Services  None  Other: \_\_\_\_\_

Name and address of other doctor's who have treated you for this condition: \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ Blood Test(s) \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-ray \_\_\_\_\_ Urine Test(s) \_\_\_\_\_

Dental X-ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place an **X** on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostrate Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Exercise:**  None  Moderate  Daily  Heavy

**Work Activity:**  Sitting  Standing  Light Labor/Lifting  Heavy Labor

**Habits:**  Smoking

Packs a Day: \_\_\_\_\_

Alcohol

Drinks per Week \_\_\_\_\_

Coffee/Caffeine Drinks

Cups per day: \_\_\_\_\_

High Stress

Reason: \_\_\_\_\_

Are you pregnant? Yes No Due Date: \_\_\_\_\_

**List any injuries/ surgeries you have had:**

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
	_____	_____
	_____	_____

**List all Medications / Vitamins /Herbs or Minerals you are currently taking:**

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy you use: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_