CONFIDENTIAL PATIENT INFORMATION

Name:_____ SSN:_____-_____-_____ Date:_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ Birth Date:_____ Age:____ Marital: S M W D

Employer:_____ Occupation:_____

Address:_____ Phone:_____

Spouse's Name:_____Birth Date:_____SSN:_____-_____-_____

Employer:_____ Phone:_____

Email: _____ May we send you our newsletter? ☐ Yes ☐ No

HEALTH HISTORY

Purpose of Appointment (Major Complaint):_____

Explain what happened:_____

Date symptoms appeared:_____ Have you ever had the same or similar symptoms? ☐ Yes ☐ No

If yes, when and describe: _____

Is current condition: ☐ Job related ☐ Auto accident ☐ Other:_____

Other doctors seen for this condition: _____

Do you have any other health conditions at this time? ☐ Yes ☐ No If yes, describe: _____

(Females only): When was your last period? _____ Are you pregnant now? ☐ Yes ☐ No ☐ Not Sure

Check all of the following which apply to you:

☐ Headache	☐ Shoulder Pain ☐R ☐L	☐ Dizziness	☐ Chest Pain	☐ Cold Sweats
☐ Neck Pain	☐ Arm/hand Pain ☐R ☐L	☐ Sleeping Problems	☐ Loss of Smell	☐ Cold Hands
☐ Mid-back Pain	☐ Hip/leg Pain ☐R ☐L	☐ Nervousness	☐ Loss of Taste	☐ Cold Feet
☐ Low-back Pain	☐ Arm Numbness ☐R ☐L	☐ Ringing in ears	☐ Diarrhea	☐ Face Flushed
☐ Jaw Pain	☐ Leg Numbness ☐R ☐L	☐ Memory Loss	☐ Constipation	☐Fainting Spells

Symptoms other than above: _____

Check all of the following items that apply to your condition:

☐ Dull Pain ☐ Sharp Pain ☐ Constant Pain ☐ Pain off & on ☐ Worse in Morning ☐ Worse in Evening

Worse with: ☐ Sitting ☐ Laying ☐ Standing ☐ Driving ☐ Lifting Heavy Objects ☐ Other: _____

PAST HEALTH HISTORY

Surgeries: _____Broken Bones: _____

Serious Illness/conditions: (heart disease/attack, stroke, cancer, diabetes, high blood pressure, lung disease, epilepsy)

Other:_____

Any Serious Illness or Disease in your Family? _____

Prior Accidents or Injuries: (Date and type of injury) 1. _____ 2. _____

Previous Chiropractic Care: ☐ Yes ☐ No Doctor's name and last visit date: _____

Allergies:_____ Do You Exercise? Y/N Times Per Week_____

Do You: Smoke? Y/N How Much?_____ How long?____ Drink Alcohol? Y/N How Much?_____

List your medications: _____

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AUTO ACCIDENT HISTORY

Date of Accident:_____Time: _____ AM PM Location: _____

Were you: ☐ Driver? ☐ Front passenger? ☐ Rear passenger? ☐ other?:_____

Year and model of your auto: Year: _____ Make: _____ Model: _____

Were you wearing a seatbelt? ☐Yes ☐No Describe any injury from seatbelt: _____

Road conditions at time of accident: ☐Dry ☐Wet ☐Icy ☐Other: _____

Was your auto struck from: ☐ Behind? ☐ Front? ☐ Right Side? ☐ Left Side? ☐ Other: _____

Was your auto stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No

If no, then estimate your auto's speed: _____ mph. Was your auto: ☐Slowing down ☐Gaining speed ☐Steady Speed

Did your auto strike the other(s) involved? ☐ Yes ☐ No; Or did the other auto strike yours? ☐ Yes ☐ No

Which car parts broke during the accident: ☐windshield ☐side window ☐steering wheel ☐seat back ☐_____

What is the estimated cost damage to the auto you were in? $_____

Was your body pointed straight forward? ☐Yes ☐No If no, what direction? _____

Was your head pointed straight forward? ☐Yes ☐No If no, what direction? _____

Did any part of your body hit against the auto during the accident? ☐Yes ☐No Describe: _____

Did you go to the hospital after the accident? ☐ Yes ☐ No Hospital: _____ Date:_____

Were x-rays taken? ☐ Yes ☐ No Other Doctors seen for injuries? ☐ Yes ☐ No Name: _____

Have you missed any time from work? ☐ Yes ☐ No Dates: _____ to _____

Year and model of the other auto: Year: _____ Make: _____ Model: _____

Was the other auto stopped at the time of impact? ☐Yes ☐No If no, what was the other auto's speed: _____ mph.

Was the other auto: ☐Slowing down ☐Gaining speed ☐Steady Speed

Please describe what happened during the accident: _____

_____

_____

INSURANCE INFORMATION

Who is responsible for your bill? Myself and ☐ Spouse ☐ Auto Insurance ☐ Personal Insurance ☐ Medicare

Auto Ins Co.: _____ Do you have Medical Payments? Y / N

Address:_____ Phone:_____

Insured Name:_____ Claim #:_____ Adjuster:_____

Health Ins. Co. Name: _____ Phone: _____ Group #:_____

Insured Name:_____ Insured ID#:_____ Date of Birth _____

Attorney Name: _____ Phone: _____

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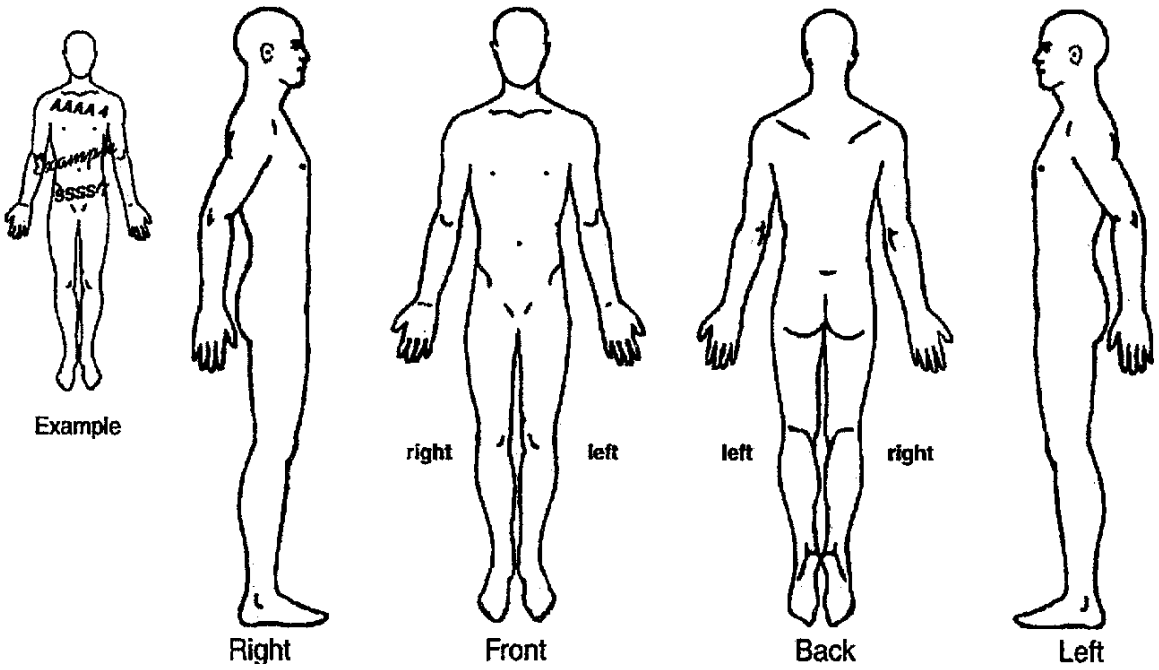
Pain Chart

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

○ Circle any area of pain not represented by a symbol.



Financial Policy

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. I also authorize my insurance company to make payment directly to this office. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney fees, and/or court costs will be added to the total amount due.

I have read the office financial policy, and agree to abide by its terms.

Patient/Guardian Signature: _____Date:_____

AUTHORIZATION FOR TREATMENT, MEDICAL RELEASE, AND INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various physical therapy modalities and x-rays on me by the doctor of chiropractic and/or other licenced doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic and/or other office personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature: _____Date:_____