№ 00807 **CONFIDENTIAL PATIENT INFORMATION** DATE ___/___/___

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME_____ DATE OF BIRTH ___/___/___ AGE ___ Male☐ Female☐

ADDRESS_____ APT#_____ SSN ____ - ____ - ____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (_____)_____

ALTERNATE PHONE (CELL): (_____)_____ EMAIL ADDRESS: _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE ____ ZIP _____

WORK PH. # (_____)_____ EXT._____ DATE SYMPTOMS BEGAN: ___/___/___

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____PHONE_____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐

TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐

I WILL BE PAYING TODAY BY CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____

INSURED'S EMPLOYER SAME AS ABOVE ☐ _____

INSURED'S SSN SAME AS ABOVE ☐ SSN ____ - ____ - ____ INSURED'S DOB SAME AS ABOVE ☐ ___/___/___

PRIMARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

****

SECONDARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement 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 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 also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬬. **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR
01 07	01	0
02 08	02 10	1
03 09	03 20	2
04 10	04 30	3
05 11	05 40	4
06 12	06 50	5
	10 07 60	6
	20 08 70	7
	30 09 80	8
		90 9

DR# PATIENT NUMBER

Date Of Birth

Social Security #

Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Widowed ○Divorced ○Other

Patient's Home Address

Phone FAX

Patient Resides With: ○Lives Alone ○Spouse ○Parents ○Children ○Other

Children: ○0 ○1 ○2 ○3 ○4 ○5+

Employer Business Address

Phone

Occupation

Referred By

Spouse Name

Social Security #

A. MAJOR COMPLAINTS

1. What are your major complaints?

○None	Pain	Numbness	Tingling
Head	H	H	H
Neck	N	N	N
Upper Back	U	U	U
Mid Back	M	M	M
Lower Back	L	L	L

	R	L	R	L	R	L
Shoulder	S	S	S	S	S	S
Arm	A	A	A	A	A	A
Forearm	F	F	F	F	F	F
Hand	H	H	H	H	H	H
Buttock	B	B	B	B	B	B
Hip	H	H	H	H	H	H
Thigh	T	T	T	T	T	T
Leg	L	L	L	L	L	L
Foot	F	F	F	F	F	F

2. Currently your pain is aggravated by

○Coughing ○Lifting
○Sneezing ○Bending
○Straining At Stool ○Sitting
○Neck Movement ○Standing
○Reaching ○Walking
○Other

3. Since your symptoms began, have you noticed a change in

○Bowel Function ○Bladder Function
○Ability To Maintain An Erection

B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

1. a. GENERAL
○Normal ○Chills
○Fatigue ○Weight Change
○Weakness ○Night Sweats
○Fever ○Other

b. SKIN
○Normal ○Eczema
○Rash ○Hair Changes
○Redness ○Nail Changes
○Itching ○Other

c. NEUROLOGIC
○Normal ○Fainting
○Headache ○Convulsions
○Dizziness ○Other

d. EYES

○Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

e. EARS

○Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

f. NOSE
○Normal
○Pain ○Absence Of Smell
○Bleeding ○Other

g. MOUTH/THROAT
○Normal ○Absence Of Taste
○Sores ○Abnormal Taste
○Bleeding ○Other

h. HEART/LUNGS
○Normal ○Blue Extremities
○Cough ○Murmur
○Wheezing ○Chest Pain
○Difficulty Breathing ○Palpitations
○Swollen Extremities ○Other

i. BREASTS
○Normal ○Dimpling
○Lumps In Breast(s) ○Discharge
○Redness/Itching ○Other
○Pain

j. STOMACH/INTESTINES
○Normal ○Vomiting
○Decreased Appetite ○Diarrhea
○Increased Appetite ○Constipation
○Abdominal Pain ○Other

k. REPRODUCTIVE/URINATION
○Normal ○Impotence
○Inability To Hold Urine ○Sterility
○Painful Urination ○Other
○Frequent Urination
○Irregular Menstruation
○Painful Menstruation
○Abnormal Vaginal Bleeding

l. GLANDULAR
○Normal ○Goiter
○Heat/Cold Intolerance ○Tremor
○Sugar In Urine ○Other

m. MENTAL
○Normal ○Phobias
○Anxiety ○Mood Swings
○Depression ○Other
○Memory Loss or Impairment

516636

PLEASE MAKE NO MARKS IN THIS AREA

2. What are your habits?

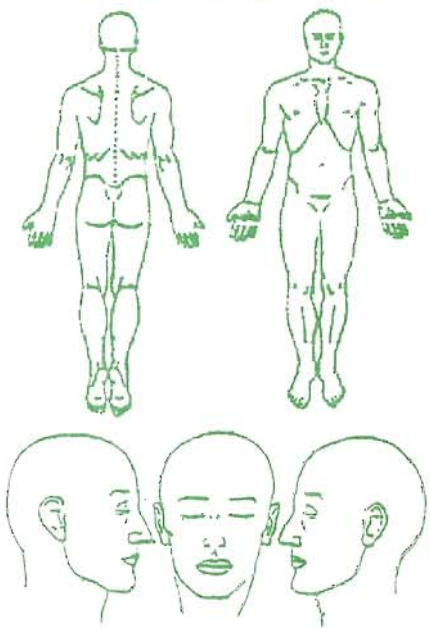
	Never	Occasionally	Moderately	Excessively
Smoking	(S)	(S)	(S)	(S)
Alcohol	(A)	(A)	(A)	(A)
Recreational Drugs	(R)	(R)	(R)	(R)
Exercise	(E)	(E)	(E)	(E)

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)
Mother	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
Brothers	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)
Sisters	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)
Children	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)

C. PAIN DIAGRAMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

	Yes	No
a. Have you been to a chiropractor	(Y)	(N)
b. Do you have a family physician	(Y)	(N)
c. WOMEN:		
To the best of your knowledge are you pregnant	(Y)	(N)
Are you under the regular care of an OB-GYN	(Y)	(N)
d. Have you been hospitalized in the past five years	(Y)	(N)
e. Are you currently taking any medication	(Y)	(N)

- ○ Anti-inflammatory (Aspirin, Motrin, etc.)
- ○ Muscle Relaxants
- ○ Pain Medication/Analgesic
- ○ Tranquilizers
- ○ Birth Control Pills
- ○ Other

2. Which of the following illnesses have you had?

- ○ *No Previous Conditions/Illnesses*
- ○ Arthritis
- ○ Asthma
- ○ Sinus Trouble
- ○ Hay Fever
- ○ Allergies
- ○ Tuberculosis
- ○ Diabetes
- ○ Epilepsy
- ○ Thyroid Trouble
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Heart Trouble
- ○ HIV/ARC
- ○ AIDS
- ○ Sexually Transmitted Disease
- ○ Ulcer
- ○ Cancer
- ○ Polio
- ○ Rheumatic Fever
- ○ Serious Injury
- ○ Bone Fracture
- ○ Dislocated Joints
- ○ Spinal Disc Disease
- ○ Multiple Sclerosis
- ○ Scoliosis
- ○ Mental/Emotional Difficulty
- ○ Prostate Trouble
- ○ Kidney Trouble
- ○ Other

E. INSURANCE INFORMATION

	Yes	No
1. Is your condition due to an automobile accident	(Y)	(N)
Date of Accident		
Have You filed an accident report	(Y)	(N)
2. Is your condition due to a job injury	(Y)	(N)
Date of Injury		
Have You filed an injury report	(Y)	(N)
3. Do you have health insurance	(Y)	(N)
Company		
Policy #		
4. Are you covered by Medicare	(Y)	(N)
Medicare #		

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F. PAYMENT

I WILL BE PAYING TODAY BY:

○ Cash ○ Check ○ Credit Card

○ MasterCard ○ Visa ○ American Express

Account # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Doctor's Signature _____ Date _____