Welcome To The Abrankian Back & Neck Center

PATIENT INFORMATION **(Please Print)**

FIRST NAME_____ LAST NAME _____ DATE_____

ADDRESS_____ APT_____ CITY_____ ZIP_____

PHONE_____ SOC. SEC. NO._____ DATE OF BIRTH_____

MARITAL STATUS: M S D W SEX: M F AGE:_____ # OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

E-MAIL ADDRESS:_____ HOW DID YOU HEAR ABOUT THIS OFFICE:_____

CELL PHONE #:_____

PATIENT CONDITION

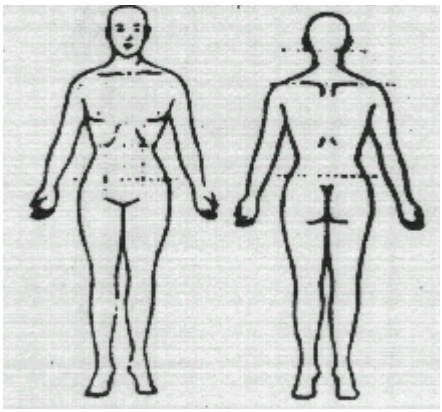
HAVE YOU HAD CHIROPRACTIC CARE BEFORE? □ YES □ NO WHEN?_____ DR. NAME:_____

DESCRIBE YOUR SYMPTOMS:_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? □ YES □ NO □ UNKNOWN

ARE YOU TAKING MEDICATIONS ? □ NO □ YES, (LIST):_____

MARK AN (X) ON THE PICTURE WHERE YOU HAVE PAIN:



TYPE OF PAIN: □ SHARP □ DULL □ THROBBING □ ACHING
□ STIFFNESS □ TINGLING □ NUMBNESS □ SHOOTING
□ OTHER:_____

HOW OFTEN DO YOU EXPERIECE YOUR SYMPTOMS ?
□ Constantly (76-100% of day) □ Frequently (51-75% of day)
□ Occasionally (26-50% of day) □ Intermittently (0-25% of day)

CIRCLE HOW BAD ARE YOUR SYMPTOMS FROM 0 -10:
0 1 2 3 4 5 6 7 8 9 10
(NO PAIN) - - -(MODERATE)- - -(SEVERE PAIN)

WHAT ACTIVITIES MAKE YOUR SYMPTOMS *WORSE:*
□ Sitting □ Standing □ Walking □ Bending □ Lifting □ Lying Down □Other: _____

WHAT ACTIVITIES MAKE YOUR SYMPTOMS *BETTER*:
□ Sitting □ Standing □ Walking □ Bending □ Lifting □ Lying Down □Other: _____

DOES YOUR SYMPTOMS INTERFERE WITH YOUR? □ WORK □ SLEEP □ DAILY ROUTINE □ RECREATION

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? □ No □ Yes Explain:_____

WOMEN: I have been advised that if I am pregnant and have x-rays taken which may expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for X-ray examinations. With those factors in mind, I am advising my doctor that:

	YES	NO	Don't Know
I am pregnant.	_____	_____	_____
I am late with my menstrual period.	_____	_____	_____
I am taking oral contraceptives.	_____	_____	_____
I have an IUD.	_____	_____	_____
I have had a tubal ligation.	_____	_____	_____
I have had hysterectomy.	_____	_____	_____

WORK ACTIVITY INCLUDE: □ Sitting □ Standing □ Light Labor □Heavy Labor

EXERCISE: □ None □ Light □ Moderate □ Daily □ Heavy

HEALTH HISTORY ***(Have you ever suffered from? Please ✓bellow)***

□Aids/HIV □ Anemia □ Arthritis □ Asthma □ Bleeding Disorders □ Breast Lumps □ Cancer □ Diabetes □ Epilepsy

□ Gout □ Heart Disease □ Kidney Disease □ Dizziness □ Digestive Disorders □ Headaches □ High Blood Press □ Osteoporosis

□ Pace Maker □ Prostate Problems □ Stroke □ Tumors □ Other:_____

List injuries and surgeries you have had:_____

ONLY IF YOUR CONDITION IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION

Please check one: □ Auto Accident □ Work Accident □ Other Date of Injury:_____ Time:_____

How did the accident happen:_____

Did you report your injury? □ Yes □ No To whom?_____

Did you go to the hospital? □ Yes □ No Where?_____

By ambulance? □ Yes □ No X-Rays taken? □ Yes □ No By whom?_____

Date(s) of hospitalization_____ Medications prescribed:_____

Are you presently working ? □ Yes □ No Last date you worked:_____

Have you been treated by any other doctor for this injury ? □ Yes □ No
Whom?_____

DO YOU HAVE HEALTH INSURANCE? □ Yes □ No *IF YES:* ***Please print below & Give us a copy of the card.***

Name of Insurance Company(s)_____

GROUP#_____ MEMBER ID#_____

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Date_____ Patient's Signature_____