WELCOME

SEND FORM

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: (•) M ( ) F Age _____ Birthdate _____

(•) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ( ) Yes (•) No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) 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 Date

PHONE NUMBERS

Home _____ Work _____ Ext ____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext ____

ACCIDENT INFORMATION

Is condition due to an accident? ( ) Yes (•) No Date _____

Type of accident (•) Auto ( ) Work ( ) Home ( ) Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

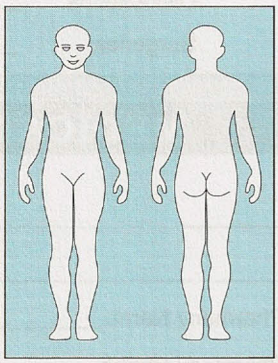
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ( ) Yes (•) No ( ) 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 from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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

– OVER –

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

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

EXERCISE

● None
○ Moderate
○ Daily
○ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day_____
☐ Alcohol Drinks/Week_____
☐ Coffee/Caffeine Drinks Cups/Day_____
☐ High Stress Level Reason_____

Are you pregnant? ○ Yes ● No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

Pharmacy Name_____
Pharmacy Phone_____

ALLERGIES

VITAMINS/HERBS/MINERALS