Date _____

SS/HIC/Patient ID# _____

Patient Name _____

Address _____

City _____

State _____Zip _____

Home Phone (_____) _____

Cell Phone (_____) _____

E-mail Address _____

Sex ☐ M ☐ Female

Date of Birth _____ Age _____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for ___ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Whom may we thank for referring you?

_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____

Primary Insurance _____

Policy # _____

Group # _____

Name of Insured _____

Insured's Date of Birth _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my heath care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

_____ Date _____
Signature of Patient or Legal Guardian

_____ Date _____
Printed Name of Patient or Legal Guardian

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

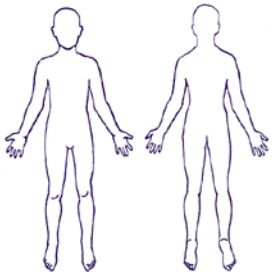
Attorney Name (if applicable)_____

Reason for Visit _____
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes
☐ No ☐ Unknown

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 _____

Mark an X on the picture where you continue to have pain, numbness or tingling.



Front Back

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

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 _____

_____
_____

Circle any of the following, which you have had:

AIDS/HIV Diabetes Migraine Headaches

Rheumatic Fever Alcoholism Emphysema

Miscarriage Scarlet Fever Allergy Shots

Epilepsy Mononucleosis Stroke

Anemia Fractures Multiple Sclerosis

Suicide Attempt Anorexia Glaucoma

Mumps Thyroid Problems Appendicitis

Goiter Osteoporosis Tonsillitis

Arthritis Gonorrhea Pacemaker

Tuberculosis Asthma Gout

Parkinson's Disease Tumors, Growths

Bleeding Disorders Heart Disease

Pinched Nerve Typhoid Fever Breast Lump

Hepatitis Pneumonia Ulcers

Bronchitis Hernia Polio

Vaginal Disease Bulimia

Herniated Disk Prostate Problem

Venereal Disease Cancer

Herpes Prosthesis Whooping Cough

Cateracts High Cholesterol Psychiatric Care

Chemical Dependency Kidney Disease

Rheumatoid Arthritis Chicken Pox

Liver Disease Measles

Other _____

EXERCISE
None Moderate Heavy

WORK ACTIVITY
Sitting Standing Light Labor Heavy Labor

HABITS
Smoking *Packs/Day* _____
Alcohol *Drinks/Week*_____
Coffee *Cups/Day*_____
Heavy Labor
High Stress Level

Are you pregnant? ☐Yes ☐No
Due Date _____

Injuries/Surgeries you have had
Description Date
Falls
_____
_____

Head Injuries
_____
_____

Broken Bones
_____
_____

Dislocations
_____
_____

Surgeries_____
_____