PATIENT'S PRESENT COMPLAINTS

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ Soc. Sec. #_____

Drivers Lic. #_____ Age___ Birthdate_____ M/F Status M/ S/ W/ D No. Children___

Occupation_____ Employer_____ Phone_____ Years_____

Address_____ City_____ State_____ Zip_____

Spouse's Name_____ Birthdate_____ Soc. Sec. #_____

Occupation_____ Employer_____ Address/Phone_____

Do you have insurance? ☐ Yes ☐ No If yes, do you want us to bill it for you? ☐ Yes ☐ No

I have been queried regarding possessing insurance coverage and have declined to have my insurance billed. ( ) Initial

Person Responsible_____ Health Plan_____

Subscriber's Name_____ I.D.#_____ Group #_____

Primary Care Physician_____ Phone _____

Any chiropractor consulted in the past? Name_____ Dates Consulted_____

Whom may we thank for referring you?_____ Address/Phone_____

Name of Emergency Contact_____ Address/Phone_____

Date problem began _____ Describe your problem and how it began_____

_____

_____

_____

Did it appear ☐ Immediately ☐ Slowly ( ) Weeks ( ) Months ( ) Years

Has it happened before? ☐ Yes ☐ No

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Unbearable Pain)

How often are your symptoms present?	☐Constantly	☐Frequently	☐Occasionally	☐Intermittently
Describe your current pain/symptoms	☐Sharp/Stabbing	☐Throbbing	☐Aches	
	☐Dull	☐Soreness	☐Weakness	
	☐Numbness	☐Shooting	☐Gripping	
	☐Burning	☐Tingling	☐Other	_____
Since it began, is your problem:	☐Improving	☐Getting Worse	☐No Change	
What makes the problem better?	☐Nothing	☐Lying Down	☐Walking	
	☐Standing	☐Sitting	☐Movement	
	☐Exercise	☐Inactivity/Rest	☐Other	_____
Can you perform your daily home activities?	☐Yes	☐Yes, Only With Help	☐Not At All	
Do you exercise?	☐Yes, Almost Daily	☐Yes, Occasionally	☐Not At All	
Describe your job requirements:	☐Mainly Sitting	☐Light Labor	☐Heavy Labor	
Can you perform your daily work activities?	☐Yes, All Activities	☐Only Some	☐Not At All	
Describe your stress level:	☐None to Mild	☐Moderate	☐High	

What treatment have you had for this condition in the past? (Surgery, Medications, Injections, Therapy, Chiropratic)_____

_____

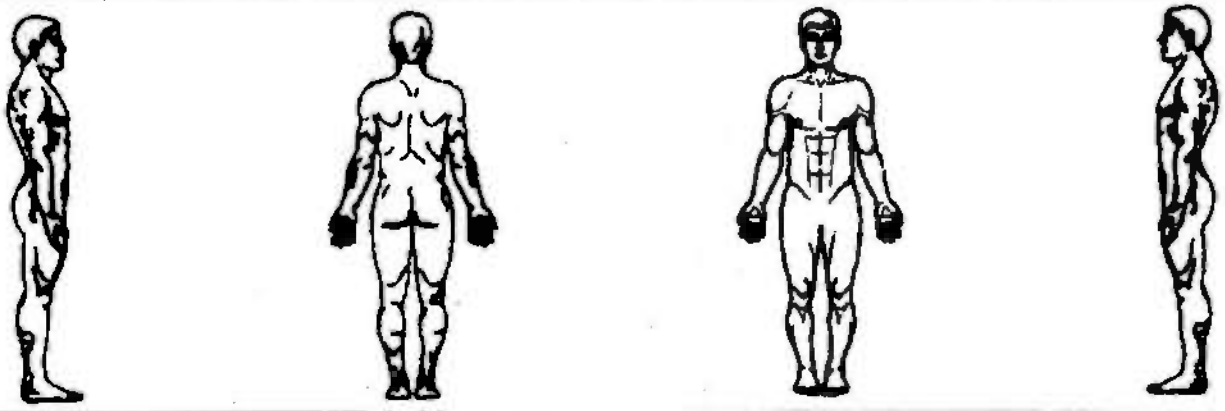
_____

Have you had x-rays, MRI, or other tests for this condition? What tests and when?_____

_____

IMPORTANT: PLEASE CHECK ALL SYMPTONS ON NEXT PAGE

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



WHO IS RESPONSIBLE FOR YOUR BILL: ☐Self ☐ HMO/PPO ☐ Workman's Comp. ☐ Auto Ins. ☐ Medicare ☐ Group Ins.

IF INSURANCE . . . Fill in below and present all insurance I.D. cards.

Primary Ins. Co._____ Sec. Ins. Co._____ Group #_____

Work Comp. Ins._____ Claim #_____

IF WORK RELATED INJURY . . . Who did you report the injury to at work? _____

Have you made a written report of your injury to your employer? ☐ Yes ☐ No *DWC-1 Filed? ☐ Yes ☐ No

Accident: Date_____ Work Comp/Auto Accident (Circle One)

Your Automobile Ins._____ Ph. ( ) _____ Pol./Claim #_____

Attorney:_____ Address: _____ Ph. ( ) _____

If this is an accident-related injury, you must fill out the Accident Form. THANK YOU!

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check Care ☐ Check here if you want the Doctor to select the type of care desired so that we may be guided by your wishes whenever possible.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on 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 professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed that the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I also understand that any services rendered are with my consent and approval.

Patient's Signature X _____ Date _____

(Signature Authorizing Care)

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above Doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. (X) _____ I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health plan coverage in the future.

Patient's Signature X _____ Date _____

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ Patient I.D.#_____

If you have ever had a listed symptom in the past, please check that symptom in the "Past" column. If you are presently troubled by a particular symptom, please check that symptom in the "Present" column. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Pres	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R___ L___)
☐	☐	Pain in Upper Arm or Elbow (R___ L___)
☐	☐	Hand Pain (R___ L___)
☐	☐	Wrist Pain (R___ L___)
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R___ L___)
☐	☐	Pain in Lower Leg or Knee (R___ L___)
☐	☐	Pain in Ankle or Foot (R___ L___)
☐	☐	Sore Muscles
☐	☐	Weak Muscles
☐	☐	Walking Problems
☐	☐	Ruptures
☐	☐	Broken Bones
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Anorexia
☐	☐	Excessive Thirst
☐	☐	Chronic Sinusitis
☐	☐	Irregular Menstral Flow
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	PMS
☐	☐	Painful Irritation
☐	☐	Abdominal Pain
☐	☐	Difficulty in Swallowing
☐	☐	Dermatitus/Eczema/Rash

Past	Pres	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (Date)_____
☐	☐	Stroke (Date) _____
☐	☐	Asthma
☐	☐	Cancer (Explain)_____
☐	☐	Tumor (Explain)_____
☐	☐	Prostrate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (Chronic Lung Disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver/Gall Bladder Problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (By Condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Loss of Appetite
☐	☐	Abnormal Weight ☐ Gain ☐Loss
☐	☐	Chronic Cough
☐	☐	General Fatigue
☐	☐	Profuse Menstral Flow
☐	☐	Endometriosis
☐	☐	Loss of Bladder Control
☐	☐	Frequent Urination
☐	☐	Constipation/Irregular Bowel Habits
☐	☐	Heartburn/Indigestion

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Heart Problems ☐ Lung Problems ☐ High Blood Pressure
☐ Epilepsy ☐ Chronic Back Pain ☐ Lupus ☐ Other_____

Present Weight _____ Pounds Height ___ Feet ____Inches

Please check any of the following that apply to you:

Past	Pres	Condition
☐	☐	Pregnancy, # Births _____
☐	☐	Medications (List if Not Listed Elsewhere)
☐	☐	Alcohol
☐	☐	Coffee/Tea/Caffeinated Soft Drinks _____ Cups/Cans Per Day

Past	Pres	Condition
☐	☐	Birth Control Pills, Type _____
☐	☐	Tobacco
☐	☐	Drug or Alcohol Dependence
☐	☐	Hospitalizations/Surgical Procedures (List if Not Listed Elsewhere _____

Do you have a permanent disability rating? ☐ Yes ☐ No Location _____
Date Rating Received _____
Rating Percentage _____

Patient's Signature _____ Date_____