

1 one

WELCOME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____
CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

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INSURANCE INFO

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____
Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ____ / ____ / ____

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone#: _____

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PLEASE CONTINUE ON BACK 

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IN EVENT OF EMERGENCY

Who should we contact? _____
 Relation: _____
 Home Phone #: _____ Work Phone #: _____
 Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood Thinners Tranquillizers Insulin Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Family Health History: _____

Do you: Take Supplements or Vitamins? Yes No / Exercise? Yes No

Are you on a special diet: Yes No / Since: ____/____/____

Do you smoke? No Yes / How Much? _____ How Long? _____

Are you wearing: Heel Lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? ____ Is it comfortable? Yes No

For women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes/How long? ____ Nursing? Yes No

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ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: CASH Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

Adult Patient Parent or Guardian Spouse

AUTO / WORK RELATED ACCIDENT

1
one

2a
twoa

ABOUT YOU

Today's Date: ___ / ___ / ___ File #: _____
Name: _____

2b
twob

WORK RELATED ACCIDENT

Date & Time of Accident: _____ a.m. p.m.
Was your accident directly related to your work?
 Yes No

Briefly describe the events that occurred just before and during your accident: _____

Give the address where accident occurred: (if other than employer's address) _____

Was anyone else present during your accident?
 Yes No

Did you report your accident to your employer?
 Yes No

What recommendations did your employer make just after your accident? _____

Has this type of accident happened to you before?
 Yes No

To the best of your knowledge, has this accident occurred in your workplace before? _____ Yes No
In general:

Is your job physically stressful? _____ Yes No

Is your job mentally stressful? _____ Yes No

Is your workplace noisy? _____ Yes No

Have you changed jobs in the last year? Yes No

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ a.m. p.m.
Were you the: Driver Front Passenger Rear Passenger
If a traffic violation was issued, to whom was it issued?

Number of people in accident vehicle? _____
Did the police come to the accident site? .. Yes No
Was a police report filed? .. Yes No
Were there any witnesses? .. Yes No
Were you wearing your seat belt? .. Yes No
Was this vehicle equipped with airbags? .. Yes No
If yes, did it/they inflate? .. Yes No
In relation to the base of your skull, where was the headrest? .. Above Below At base of skull
What did your vehicle impact? Another vehicle Other

If other, explain: _____
Did any part of your body strike anything in the vehicle? Yes No
If yes, please describe: _____

Make & model of the vehicle you were occupying?

Name of the location/street on which you were traveling?

In which direction were you headed? N S E W

What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the:
 Front Rear Right Side Left Side Other
During impact, were you facing: Right Left Forward
Were you aware or surprised by the impact?
If accident vehicle made impact with another vehicle...
Make and model of that other vehicle? _____

Direction other vehicle was headed? N S E W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

PLEASE CONTINUE ON BACK

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AFTER INJURY

Did accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance or Private transportation

Name of Hospital and/or Attending doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S.

Describe any treatment you received: _____

Were X-rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury?

Yes No

Indicate the symptoms that are a result of this accident:

- Dizziness Difficulty sleeping Jaw problems Nausea
- Memory loss Irritability Arms/Shoulder pain Back pain
- Headache(s) Fatigue Numb Hands/Fingers Lower back pain
- Blurred vision Tension Chest pain Back stiffness
- Buzzing in ear Neck pain Shortness of breath Leg pain
- Ears ringing Neck stiff Stomach upset Numb Feet/Toes
- Other _____

Is your condition getting worse?

Yes No Constant Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable <small>even if only sometimes</small>	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: Yes No

If yes, whom: _____

His/Her Phone #: _____

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RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

- Standing Driving Operating equipment
- Sitting Twisting Work with arms above head
- Walking Crawling Typing
- Lifting Bending Stooping

Other _____

What positions can you work in with minimum physical effort and for how long? _____ N/A

Prior to the injury were you capable of working on an equal basis with others your age? . . Yes No N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery, is there any light duty work you could request? Yes No N/A

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ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. / /

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

_____/_____/_____
SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY



PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Please describe your condition:

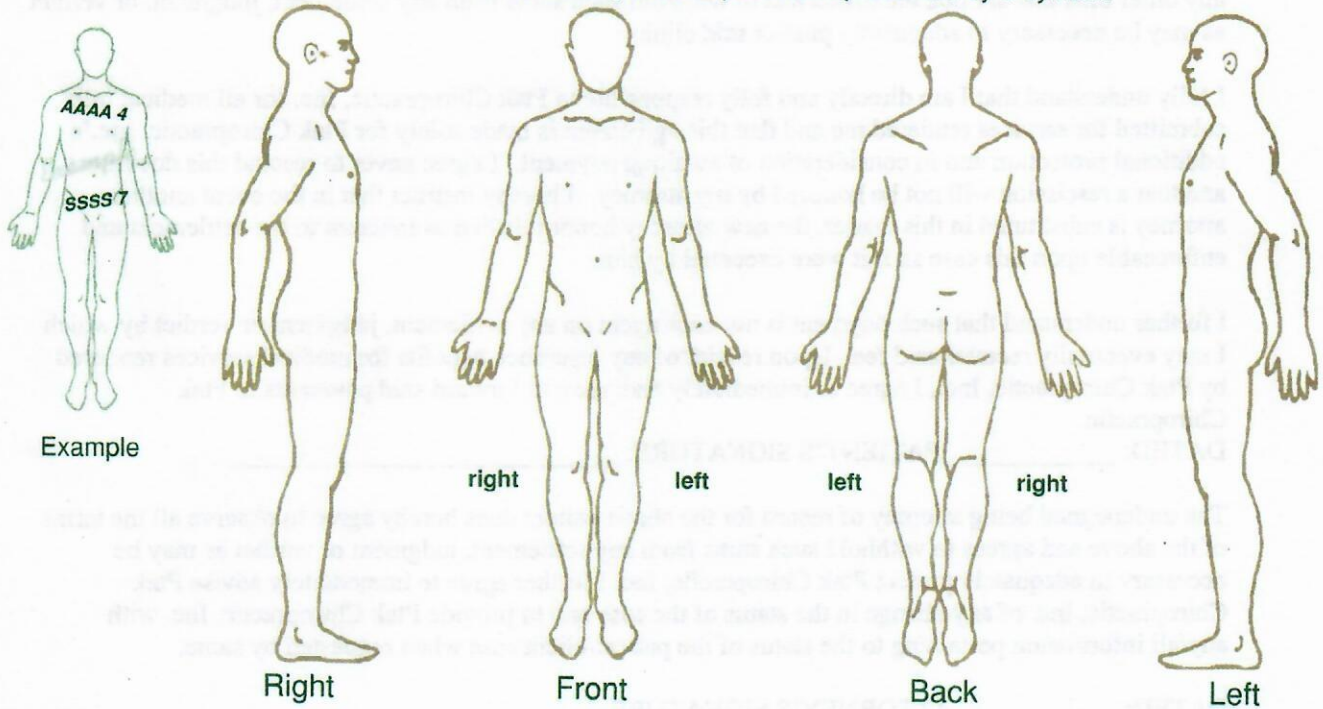
Signature: _____ Date: ____ / ____ / ____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description	➤ Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol	➤ NNNN	PPPP	BBBB	AAAA	SSSS

○ Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET ♻️