

CONFIDENTIAL PATIENT INFORMATION

Native Language? _____

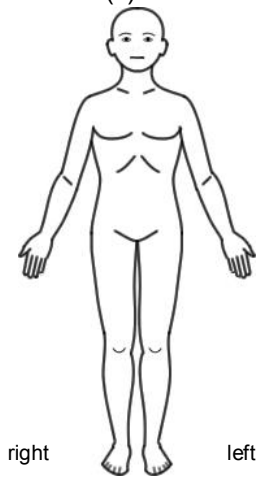
DATE _____ CLINIC# _____ HOME PHONE (____) _____
 NAME _____ WORK PHONE (____) _____
 ADDRESS _____ ZIP _____
 MAILING ADDRESS _____ ZIP _____
 IS THIS VISIT DUE TO AN ACCIDENT? () YES () NO () AUTO () WORK () OTHER _____

Which one of our patients may we thank for referring you? _____

Age _____ Birth Date _____ Marital Status _____ Number of Children _____
 Job Title _____ Employed By _____ SS# _____
 Name of Nearest Relative _____ Phone Number (____) _____
 Name of Wife or Husband _____ Occupation _____
 Employer _____ SS# _____ Clock or Empl.# _____

PRESENT COMPLAINT: Briefly describe symptoms: _____

PAIN CHART: Please sketch or shade in any areas where you may have symptoms or where you have pain. Draw an arrow from the word(s) that best describe your symptoms or type of pain:



right left

Stiffness

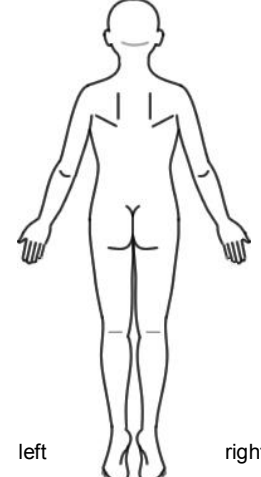
Dull (Aching)

Sharp

Burning

Tingling (Pins and Needles)

Numbness



left right

Please list other doctors seen for this condition: _____

MEDICAL HISTORY: If you have had any of the following, please check(✓) the accompanying box:

<input type="checkbox"/> Cancer	<input type="checkbox"/> German Measles	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Concussion
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> HIV
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> _____

Surgeries? (Give Dates) _____

Have you been treated by a physician in the last year? () Yes () No Condition? _____

Date of last physical exam? _____ Date of last Chiropractic Adjustment? _____

Allergies to medicine? () Yes () No What medicine(s)? _____

Are you taking any medication? () Yes () No What kind? _____

First date of last menstrual period? _____ Are you now pregnant? () Yes () No

INJURY HISTORY:

WORK RELATED INJURY

Date of Accident _____ Employer _____ Business _____
Describe Accident _____
Was accident reported to supervisor and/or employer? ()Yes ()No
Has Workers Compensation Claim been filed? ()Yes ()No

TRAFFIC ACCIDENT

Were you a: ()Driver ()Passenger ()Pedestrian	Date of Accident _____
If a passenger, where were you sitting? ()Right-Front ()Right-Rear ()Left-Rear	
What type was your vehicle? ()Car ()Truck ()Motorcycle ()Other _____	
What type was the other vehicle? ()Car ()Truck ()Motorcycle ()Other _____	
Did your vehicle hit the other vehicle? ()Yes ()No Where? _____	
Did the other vehicle(s) hit your vehicle? ()Yes ()No Where? _____	
Were you wearing a seat belt at the time of the accident? ()Yes ()No	
Were traffic citations issued? ()Yes ()No To Whom? _____	
Describe the accident including the cause(s) and surrounding circumstances: _____	
Do you have an Attorney? ()Yes ()No If so, who? _____	

PAYMENT AND INSURANCE INFORMATION: If insurance is involved, please give the necessary information to the receptionist.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that this 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 this office for my services will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature _____ Date _____
Spouse's or Guardian's Signature _____ Date _____