Welcome

M / F 1 — 2 — 3

Name _____ SS# _____

Address _____
Street and P.O. Box City State Zip

Birthdate_____ Telephone # (___) _____ Cell # (___) _____

Height _____ Weight _____Email address _____

☐ Single ☐ Married ☐ Widow / widower ☐ Divorced ☐ Legally Separated

Are you employed? Yes / No If yes, occupation _____

Name of employer _____ Telephone # (___) _____

Address _____
Street and P.O. Box City State Zip

Do you have health insurance? Yes / No

If yes, name of insurance company _____

ID#_____ Group # _____

Spouse's name _____ Birthdate _____

Does your spouse have health insurance? Yes / No Are you covered under this insurance plan?

If yes, name of insurance company _____

ID#_____ Group # _____

Name of your Primary Care Physician? _____

Whom shall we thank for referring you? _____

Reason for today's visit _____

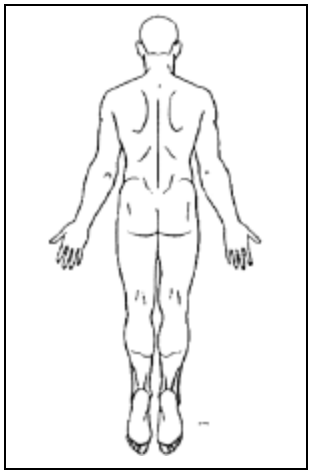
When did your symptoms appear? _____

Have you received treatment for this condition anywhere else? Yes / No

If yes, indicate the provider and treatment dates _____

Is your condition getting worse? Yes / No

Mark an X on the picture where you have symptoms ⇒



Rate the severity of your pain on a scale from 1 to 10 _____
(1 equals the least pain and 10 equals severe pain)

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

Is the pain ☐ Constant ☐ Comes and goes

What movements are painful to perform?
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying down
☐ Squatting ☐ Reaching ☐ Turning neck or back

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Is your clinic visit due to an accident? Yes / No Date of Accident_____

Type of accident: ☐ Work related ☐ Automobile ☐ Other_____

Describe the accident_____

_____

Name of insurance carrier for the accident _____

Address of carrier _____

Claim # _____Insurance carrier telephone# (___) _____

over please

HEALTH HISTORY

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

☐ Yes ☐ No AIDS / HIV
☐ Yes ☐ No Allergy Shoots
☐ Yes ☐ No Anemia
☐ Yes ☐ No Anorexia
☐ Yes ☐ No Appendicitis
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Asthma
☐ Yes ☐ No Bleeding Disorders
☐ Yes ☐ No Breast Lump
☐ Yes ☐ No Bronchitis
☐ Yes ☐ No Bulimia
☐ Yes ☐ No Cancer
☐ Yes ☐ No Cataracts
☐ Yes ☐ No Chicken Pox
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Goiter
☐ Yes ☐ No Gonorrhea
☐ Yes ☐ No Gout
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Hernia
☐ Yes ☐ No Herniated Disk
☐ Yes ☐ No Herpes
☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Measles
☐ Yes ☐ No Migraine Headaches
☐ Yes ☐ No Mononucleosis
☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Mumps
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Parkinson's Disease
☐ Yes ☐ No Pinched Nerve
☐ Yes ☐ No Pneumonia
☐ Yes ☐ No Polio
☐ Yes ☐ No Prostate Problems
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Tumors, Growths
☐ Yes ☐ No Typhoid Fever
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Whooping Cough
☐ Yes ☐ No Other _____
_____
_____

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress Level

Packs a day_____
Drinks / Week _____
Cups / Day _____
Reason _____

Are you pregnant? ☐ Yes ☐ No Due date _____

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

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS

I authorize the doctor and whomever he/she may designate as his/her assistant to administer care, which is considered therapeutically necessary on the basis of findings during the course of my treatment. With regard to insurance, I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and I authorize the release of any information pertinent to my care to any insurance company, employer and adjustor or attorney involved in my case, and that I authorize assignment of benefits any amount authorized be paid directly to this office and will be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand and agree that if my insurance plan does not cover any of the services provided for any reason, ie: referral, non -covered service, etc., that I am responsible for the charges.

Patient's signature _____Date_____

Guardian's signature (if applicable) _____Date_____