Patient Information

Name_____ Phone_____ Other Phone_____

Address_____ City_____ St_____ Zip_____

Marital Status (Circle One) M S D W Date of Birth_____ Age_____

Email:_____

We may leave voice mail messages at: (Circle all that apply) Home Work Cell

Occupation_____ Employer_____

Spouse's Name_____ # of children_____

Whom may we thank for referring you to or office?_____

Have you ever had Chiropractic care before? Yes No Date_____

We may share general information with the following person(s):_____

Is this injury or illness related to: Auto Accident Work Home Other No

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.

RELIEF CARE:

Relief Care is the care necessary to get "rid of it". It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE:

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting..

Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursed for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Superbills will be provided for individuals to submit their own bills insuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

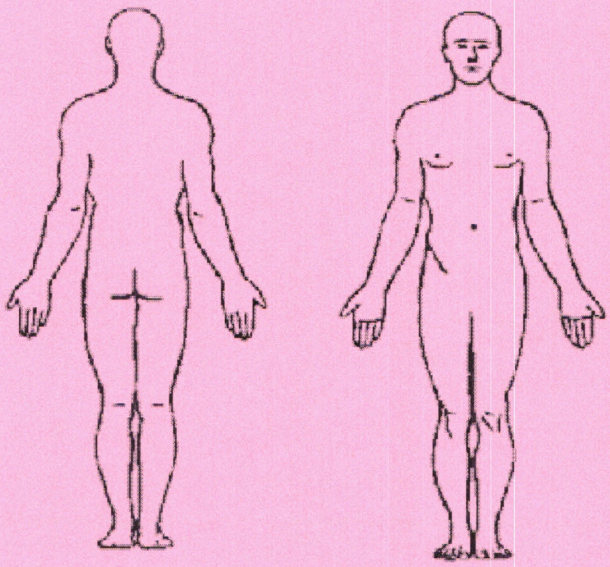
All charges are due when services are rendered…

Method of payment: Check Cash Credit Card Care Credit Medicare
(circle one)

Insurance ID(s):_____

THANK YOU FOR ALLOWING US TO SERVE YOU!!!

Please mark an 'X' on the picture where you have pain, numbness or tingling:



How can we help you? Please list any and ALL: Pain, Problems or Concerns?

1._____

Severity of your pain: 1 2 3 4 5 6 7 8 9 10
(least pain) (Severe pain)

2._____

Severity of your pain: 1 2 3 4 5 6 7 8 9 10
(least pain) (Severe pain)

3._____

Severity of your pain: 1 2 3 4 5 6 7 8 9 10
(least pain) (Severe pain)

4._____

Severity of your pain: 1 2 3 4 5 6 7 8 9 10
(least pain) (Severe pain)

When did these symptoms appear?

_____

_____

Are your symptoms getting worse? **Yes** **No** **Unknown**

Type of pain (please circle): Sharp Burning Dull Numbness Shooting
Dizziness Stiffness Tightness Swelling Tingling Other:_____

What aggravates your symptoms? (please circle):
Everything Sitting Standing Walking Bending Lying Down Nothing Other:_____

How often is the pain? Constant Daily Weekly Monthly

Please list all of the following: **Date**

Falls/Broken Bones:_____

Surgeries:_____

Medications:_____

Check any of the following you have had in the last six months:

( ) Headaches
( ) Sinus Congestion/Allergies
( ) Vision Problems
( ) Ear Aches
( ) Dizziness
( ) Heart Problems
( ) Lung Problems/Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostrate/Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Numbness
( ) Frequent Nausea/Vomiting
( ) Abdominal Cramps
( ) Constipation
( ) Diarrhea
( ) Poor/Excessive Appetite
( ) Excessive Thirst
( ) Painful/Excessive Urination
( ) Discolored Urine
( ) Diabetes
( ) Cancer

Are you pregnant? Yes No Not Sure