Patient Information

Email: We may leave voice mail messages at: (Circle all that apply) Home Work Cell Occupation	A							
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 an 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 fit". It is the same as drying a floor that was getting wet from a leak, but not fixing the leak. Due to changes in health insurance fees, patient self billing allows us to keep our fees low so you can get the care you nee without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longe be sent to your insurance provider. Superbills will be provided for individuals to submit their own bills insuring the 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)	X							
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Insurance ID(s):		patient, to get reimburse without any added cost. be sent to your insurance as your insurance provided. All charges are due whe Method of payment:	d for your care. Therefore, our pe provider. Supeder pays for your	Self billing all bolicy is that a brills will be care, they will be ndered	lows us to kee all payment is deprovided for in a send the reim	p our fees low so lue at the time of adividuals to sub- abursement check	you can get to service and be mit their own directly to yo	the care you need ills will no longed bills insuring that the but.
		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?

53	F	1Severity of your pain:	1 2 3 (least pain)	4	5	6	7	8 (Sev	9 vere	10 pain)
HH	从·利	2Severity of your pain:	1 2 3 (least pain)	4	5	6	7	8 (Sev	9 vere	10 pain)
	6(1)	Severity of your pain:	1 2 3 (least pain)	4	5	6	7		9 vere	10 pain)
		Severity of your pain:	1 2 3 (least pain)	4	5	6	7	8 (Sev	9 vere p	10 pain)

When did these symptoms appear?

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Are your symptoms getting wo	rse? Yes	No Unk	nown		
Type of pain (please circle):	Sharp	Burning	Dull	Nun	bness Shooting
Dizziness Stiffness Ti	ghtness	Swelling	Tingling		Other:
What aggravates your symptor	ns? (please circ	cle):			
Everything Sitting Star	nding Walk	ing Bendin	g Lying	Down	Nothing Other:
How often is the pain? Con	nstant Daily	Weekly	Monthly		
Please list all of the following:				Dat	
Falls/Broken Bones:					
Surgeries:					自然的表现
Medications:					
Check any of the following you	have had in th	e last six month	s:		
() Headaches		de Swelling		()	Poor/Excessive Appetite
() Sinus Congestion/Allergies	() Pros	strate/Sexual Dys	sfunction	()	Excessive Thirst
() Vision Problems	() Mei	nstrual Cycle Dy	sfunction	()	Painful/Excessive Urination
() Ear Aches	() Nur	mbness		()]	Discolored Urine
() Dizziness	() Free	quent Nausea/Vo	miting	()	Diabetes
() Heart Problems	() Abo	lominal Cramps		()	Cancer
() Lung Problems/Congestion	() Con	stipation			
() Blood Pressure Problems	() Dia	rrhea			