



NAME:		DATE:			
ADDRESS:					
CITY/STATE/ZIP:					
HOME PH #:					
CELL #:					
EMAIL ADDRESS:					
DATE OF BIRTH:		AGE:	GENDER:	M	F
HEIGHT:					
WEIGHT:					
EMPLOYER:					
JOB TITLE:					
WORK PH #:					
WORK ADDRESS:					
CITY/STATE/ZIP:					
SOCIAL SECURITY #:					
MARITAL STATUS (Circle): Single Married Divorced Widowed			CHILDREN Y N 1 2 3 4 5		

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

Have you ever received chiropractic care from another clinic or doctor prior? DR. _____
Please tell us how you heard about us: **Yellow Pages** **Insurance Directory** **Ads** _____ **Website**
Referral from a friend _____ **Search Engines** _____ **Other** _____

IS THIS VISIT RELATED TO A:		
<input type="checkbox"/> Work Related Injury	<input type="checkbox"/> Motorcycle-Bicycle Injury	<input type="checkbox"/> Home Injury
<input type="checkbox"/> Sports or Recreational Injury	<input type="checkbox"/> Non-Injury Symptoms	<input type="checkbox"/> Check-up Only
<input type="checkbox"/> Car Crash Injury	<input type="checkbox"/> School/Employment Physical	<input type="checkbox"/> Other (Describe):

CLAIMS INFORMATION (AUTO AND/OR WORKERS' COMP ONLY)

INSURANCE COMPANY	
INSURANCE ADDRESS	
POLICY #	
CLAIM #	
ADJUSTER'S NAME	
ADJUSTER'S PH#	
INSURED'S NAME	(SELF) OR INDICATE NAME:
PIP LIMITS (IF KNOWN)	

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR REGULAR INSURANCE PATIENTS.

Patient Signature: _____ **Date:** _____



PATIENT NAME _____

Date _____

GENERAL SYMPTOMS Please check your **current** and/or **past** symptoms and indicate year first noticed.

<p>GENERAL</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Chills <input type="checkbox"/> Dental problems <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tiredness <input type="checkbox"/> Weight gain <p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – flashes <input type="checkbox"/> Vision – halos <p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other _____ <p>WOMEN only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____ Date of last menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? Yes _____ No _____ Are you pregnant? Yes No
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NECK, BACK, EXTREMITIES Please check your **current** and/or **past** symptoms and indicate year first noticed.

<p>NECK</p> <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck weakness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding/popping sounds in neck <p>SHOULDERS</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td> <input type="checkbox"/> Above shoulder level</td> <td></td> <td></td> </tr> <tr> <td> <input type="checkbox"/> Over head</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> </table> <p>MID-BACK</p> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms in mid-back		Right	Left	<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain across shoulders			<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Above shoulder level			<input type="checkbox"/> Over head			<input type="checkbox"/> Tension in shoulders			<input type="checkbox"/> Pinched nerve in shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L	<p>ARMS & HANDS</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in upper arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in elbow</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in forearm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in hand</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input 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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date