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#_____

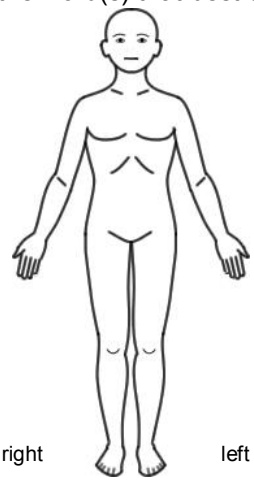
Name of Nearest Relative_____ Phone Number (____)_____

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:



Stiffness

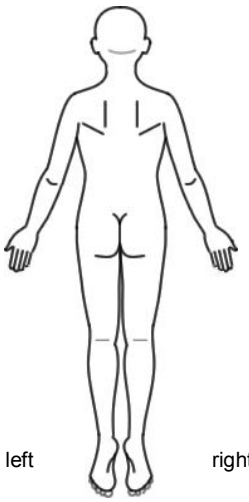
Dull (Aching)

Sharp

Burning

Tingling (Pins and Needles)

Numbness



Please list other doctors seen for this condition:_____

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

( )Cancer	( )German Measles	( )Arthritis	( )Asthma
( )Polio	( )Venereal Disease	( )Neuritis	( )Anemia
( )Tuberculosis	( )Muscular Dystrophy	( )Rheumatism	( )Concussion
( )Diabetes	( )Convulsions/Epilepsy	( )Rheumatic Fever	( )HIV
( )Hepatitis	( )Multiple Sclerosis	( )Scarlet Fever	( )_____

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_____