



**Patient Information** Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Cell (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
 Sex  Male  Female  Married  Widowed  Single  
 Patient Employer \_\_\_\_\_  
 Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_

**Insurance Information**

Who is responsible for the account?  Self (patient)  Other  
 Name of other responsible person: \_\_\_\_\_  
 Relationship to Patient? \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Member # \_\_\_\_\_ Group # \_\_\_\_\_  
 Is patient covered by additional insurance?  Yes  No  
 Secondary insurance company: \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Subscriber's Name: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Subscriber's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SS# \_\_\_\_\_

**Patient Condition**

(1) Do you have  Headaches  Migraines  
 If so, how often? \_\_\_\_\_  
 (2) Reason for this visit? \_\_\_\_\_  
 \_\_\_\_\_  
 (3) When did your symptoms appear? \_\_\_\_\_

**HEALTH HISTORY**

(14) What treatment have you already received for your condition?

- Medications  Surgery  Physical Therapy  Chiropractic Services  
 None  Other

(15) Name of the doctor(s) who have treated you for your condition:

\_\_\_\_\_

(16) Date of last:

Physical Exam: \_\_\_\_\_ Spinal X-Ray: \_\_\_\_\_

Blood Test: \_\_\_\_\_ Spinal Exam: \_\_\_\_\_

Chest X-Ray: \_\_\_\_\_ Dental X-Ray: \_\_\_\_\_

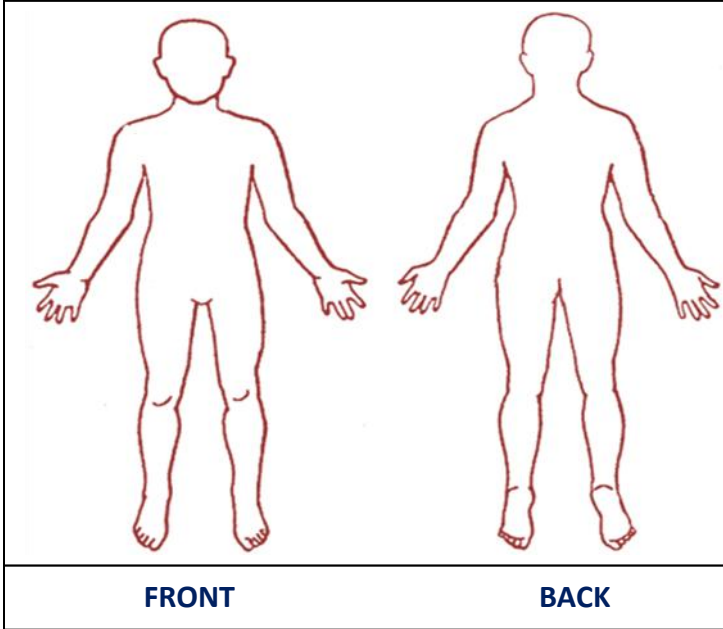
MRI, CT-Scan, Bone Scan: \_\_\_\_\_

(17) Place a mark on "Yes" to indicate if you have or had any of the following:

- |                   |                              |                   |                              |
|-------------------|------------------------------|-------------------|------------------------------|
| AIDS/HIV          | <input type="checkbox"/> Yes | Epilepsy          | <input type="checkbox"/> Yes |
| Alcoholism        | <input type="checkbox"/> Yes | Fractures         | <input type="checkbox"/> Yes |
| Allergy Shots     | <input type="checkbox"/> Yes | Glaucoma          | <input type="checkbox"/> Yes |
| Anemia            | <input type="checkbox"/> Yes | Goiter            | <input type="checkbox"/> Yes |
| Anorexia          | <input type="checkbox"/> Yes | Gout              | <input type="checkbox"/> Yes |
| Appendicitis      | <input type="checkbox"/> Yes | Hepatitis         | <input type="checkbox"/> Yes |
| Arthritis         | <input type="checkbox"/> Yes | Hernia            | <input type="checkbox"/> Yes |
| Asthma            | <input type="checkbox"/> Yes | Herniated Disk    | <input type="checkbox"/> Yes |
| Bleeding Disorder | <input type="checkbox"/> Yes | Herpes            | <input type="checkbox"/> Yes |
| Breast Lump       | <input type="checkbox"/> Yes | High Bl. Pressure | <input type="checkbox"/> Yes |
| Bronchitis        | <input type="checkbox"/> Yes | High Cholesterol  | <input type="checkbox"/> Yes |
| Bulimia           | <input type="checkbox"/> Yes | Kidney Disease    | <input type="checkbox"/> Yes |
| Cancer            | <input type="checkbox"/> Yes | Liver Disease     | <input type="checkbox"/> Yes |
| Cataracts         | <input type="checkbox"/> Yes | Measles           | <input type="checkbox"/> Yes |
| Chemical Depend.  | <input type="checkbox"/> Yes | Migraines         | <input type="checkbox"/> Yes |
| Chicken Pox       | <input type="checkbox"/> Yes | Miscarriage       | <input type="checkbox"/> Yes |
| Diabetes          | <input type="checkbox"/> Yes | Mono              | <input type="checkbox"/> Yes |
| Emphysema         | <input type="checkbox"/> Yes |                   |                              |

**(Continued on back page)**

(4) Is this symptom progressively worse?  Yes  No  
 Mark an X on the picture where you continue to have pain, numbness, or tingling.



(5) Rate the severity of your pain on a scale from 1 (least) to 10 (severe) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  
 Aching  Burning  Tingling  Cramping  
 Stiffness  Swelling

(6) How often do you have this pain? \_\_\_\_\_

(7) Is it constant or does it come and go? \_\_\_\_\_

(8) Does it interfere with your:  Work  Sleep  
 Daily Routine  
 Recreation

(9) Activities that are painful to perform:  
 Sitting  Standing  
 Walking  Bending  
 Lying Down

**Accident Information**

(10) Are any of the above conditions due to an accident?  Yes  No

(11) Type of Accident:  Auto  Work  Home  Other (please explain below)

(12) Attorney Name (if applicable): \_\_\_\_\_

(13) Attorney Telephone: \_\_\_\_\_

- Multiple Sclerosis  Yes
- Mumps  Yes
- Osteoporosis  Yes
- Pacemaker  Yes
- Parkinson's  Yes
- Pinched Nerve  Yes
- Pneumonia  Yes
- Polio  Yes
- Prostate Problem  Yes
- Prosthesis  Yes
- Psychiatric Care  Yes
- Rheumatoid Arthritis  Yes
- Rheumatic Fever  Yes
- STD  Yes
- Stroke  Yes
- Suicide Att.  Yes
- Thyroid Problem  Yes
- Tonsillitis  Yes
- Tuberculosis  Yes
- Tumors  Yes
- Typhoid Fever  Yes
- Ulcer  Yes
- Vaginal Infection  Yes

Other: \_\_\_\_\_

(20) Exercise Habits:  None  Moderate  Daily  Heavy

(21) Work Activity:  Sitting  Standing  Light  Heavy

(22) Other Habits  Smoking Packs/Day \_\_\_\_\_  Drinking

Drinks/Week \_\_\_\_\_  Caffeine Cups/Day \_\_\_\_\_

High Stress? \_\_\_\_\_

(23) Are you pregnant?  Yes  No Due Date? \_\_\_\_\_

(24) Injuries/Surgeries you have had. Describe each:

Fall \_\_\_\_\_

Head Injury \_\_\_\_\_

Surgery \_\_\_\_\_

Broken Bones \_\_\_\_\_

Dislocations \_\_\_\_\_

(25) Medications you are currently taking:

(26) Allergies: \_\_\_\_\_

(27) Vitamin/Herb Supplements: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_