WELCOME

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Name ____ **Date** ________________

PATIENT INFORMATION

Address ____
City ____________________ State _______ Zip ___________
Sex ☐ M ☐ F Birthdate ______________ Age _______
Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced
No. of Children _______
School/Employer ________________________________
Occupation ____________________ Years on Job ________
SS# ____________________
Spouse's Name ________________________________
Birthdate _________________ SS# ____________________
Employer ________________________________
Occupation ____________________ Years on Job ________
Whom may we thank for referring you? _________________

PHONE NUMBERS

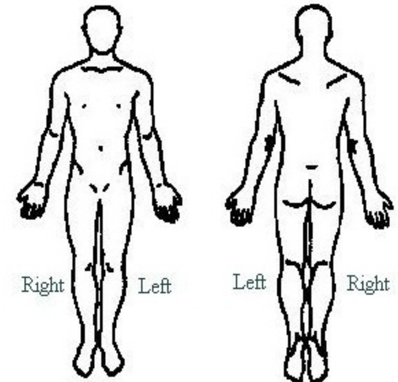
Home __________________ Work/Cell __________________
Email ____
IN CASE OF EMERGENCY, CONTACT
Name ______________________ Relationship ____________
Home _____________________ Cell ____________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No
Date of accident ________________
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other
Attorney Name (if applicable) ___________________________

PATIENT CONDITION

Mark an X on the picture where you have pain, numbness, or tingling:



Primary Complaint ____
When did your symptoms appear? ______________________________
Is the condition getting ☐ better ☐ worse ☐ same?
Have you had this before? Y / N
Rate the severity of your pain on a scale from 1 to 10 _________________
(1- 3 mild pain, 4-6 moderate pain, 7-10 severe pain with 10 being the worst pain imaginable)
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How often do you have this pain? __________________
Is it constant or does it come and go? _______________
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
What care have you received for your condition? ☐ Medications ☐ Surgery ☐ Chiropractic
☐ Physical Therapy ☐ Ice/Heat ☐ Stretching/Exercises ☐ Homeopathic ☐ None ☐ Other ____________________
List other doctors who have treated you for this condition ____

INSURANCE INFORMATION

How will your payment be made? ☐ Cash ☐ Check ☐ Visa/MC
Insurance Co. ______________________________________ Policy/Group # ______________________________
Insured ____ Relationship to Patient ______________________

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care for any reason, any fee for professional services rendered me will be immediately due and payable.

Patient/Guardian Signature ____ Date ________________________

Note: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. Thank You.