WELCOME

Please Print. The following information is needed to better serve you.
Please complete all sections. If you need help, please ask the receptionist.

NAME:_____ **DATE:**_____

PATIENT INFORMATION

Date of Birth _____ Age _____ Sex ☐ M ☐ F
Address _____
City _____ State _____ Zip _____

School/Employer _____
Occupation _____Years on Job ____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced
No. of Children _____

Spouse's Name_____
DOB_____
Employer_____
Occupation _____ Years on Job ____

How did you hear about us?_____
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 _____ Claim # _____
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

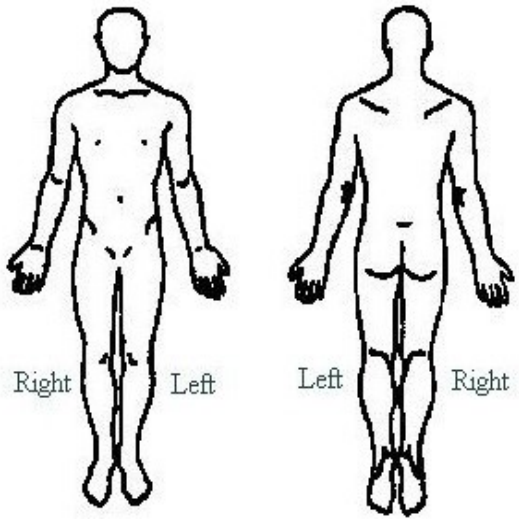
Primary Complaint(s)_____

_____

_____

When did your symptoms appear? _____
Is the condition getting ☐ better ☐ worse ☐ same?
Have you had this before? Y / N (if yes, date/ explain) _____
Rate the severity of your pain on a scale from 1 to 10 _____
1- 3 mild pain, 4-6 moderate pain, 7-9 severe pain, 10 worst pain imaginable
Pain type: (mark all that apply) ☐ 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

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



What care have you received for your condition? ☐ Medications ☐ Surgery ☐ Chiropractic
☐ Physical Therapy ☐ Ice/Heat ☐ Stretching/Exercises ☐ Homeopathic ☐ None ☐ Other _____

PAYMENT INFORMATION

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 accidental insurance policies are an arrangement between my insurance carrier and myself. I am responsible for immediate and full payment of any and ALL services covered or not covered by an insurance program.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Visa/MC/Disc/AMEX

SIGNATURE:_____**DATE:**_____