

Patient Information

Last Name:		First Name:		Mid Init:
Nickname:		Social Security No:		Your Date of Birth:
Addr:		Home Phone:		
City, State, Zip:		Cell Phone:		
Employer:		Work Phone:		
E-Mail Addr:				
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced		Spouse's Name:		Birthdate:
Spouse's Social Security No:				

How were you **referred** to our clinic?:

Insurance Information: Please have the receptionist get a copy of your insurance card for your file.

Insurance Co:		Policy Number:		Group #:
Policy Holder:		Employer:		

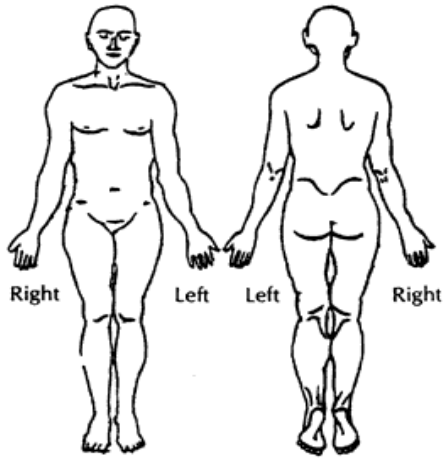
We encourage all patients to verify their insurance benefits.

NOTE: Co-payments are expected at the time of service per our contract with the insurance company. Also, we offer a discount for services paid on the day of service for patients with a deductible. There is no guarantee for coverage, but they usually state that all codes are inclusive and based on medical necessity. Please be aware that you are financially responsible for any charges not covered or paid by insurance.

Current Symptoms

Please mark the area(s) and type(s) of pain that you are experiencing.

Pins/ Needles	O O O O O
Burning	X X X X X
Aching	* * * * *
Stabbing	/ / / / / / /
Numbness	N N N N



Circle Your Pain Level (10 being the highest):

1 2 3 4 5 6 7 8 9 10

Is your pain today related to: AUTO ACCIDENT WORK COMP INJURY? Describe:

When did your pain begin? _____

Describe what happened:

Prior Symptom History

- | | |
|--|---|
| <input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints. | <input type="checkbox"/> My history HAS contributed to my current complaints. |
| <input type="checkbox"/> My current complaints DID exist before, but have not been bothering me. | <input type="checkbox"/> My history HASN'T contributed to my symptoms. |
| <input type="checkbox"/> My current complaints ALREADY existed and were worsened. | <input type="checkbox"/> I'm NOT SURE if my history has contributed. |

Prior Treatment History

What treatment have you already received for you condition?

Medication _____	Chiropractic Services _____
Surgery _____	None _____
P.T. _____	Other: _____