Welcome to our office

Name _____ Date _____ Social Security # _____

Address _____ Hm. Phone#_____Cell/Alt # _____

City _____ Zip_____ Birth Date_____ Age____ Marital status: S M W D

Occupation _____ Employer _____

Referred by _____ E-Mail address _____

Are your current problems due to an Injury? Yes No, If yes: Auto accident, On the job injury, Personal Injury.

Was the accident reported ? *Yes* *No*

If you have **Health Insurance** please present your card.

List Complaints 1. _____ *Date of onset*_____

2. _____ *Date of onset*_____

3. _____ *Date of onset*_____

Have you seen any other doctors for your chief complaint? Yes No Name _____

What was the diagnosis? _____

Do you suffer from any condition other than that for which you are Consulting us? *Yes* *No*_____

List any previous broken bones, (fractures) or dislocations _____

List all previous surgeries. _____

List all medication you are currently taking_____

List any previous trauma _____

Have You lost any weight recently without trying? *Yes* *No* Does pain keep you awake at night? *Yes* *No*

Do you have a temperature? Yes NO. Smoking history: number of years __ Packs per day__Persistent cough Yes No

Is there anything else about your health we should know about? _____

DO NOT WRITE IN THIS AREA FOR DOCTORS USE ONLY.

How did it happen?_____

Location of pain _____

Constant / Intermittent: _____Position that relieves or aggravates: _____

Has this happened before _____

Worse / better AM, PM _____

Radiation into extremity, (No) R L arm leg _____

Home care? Ice, Heat _____

Previous trauma _____ Does arthritis run in the family M F S B GF GM

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed. All records and x-rays remain the property of this office, being on file were they may be seen at any time while a patient at this office. I authorize the release of medical records to all parties liable to process all claims for reimbursement of charges incurred. The patient also agrees that he or she is responsible for all bills and any collection expenses incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

HIPPA COMPLIANCE RECEIVED _____

Patient Signature _____ **Date** _____