CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

_____
DATE

IS YOUR VISIT DUE TO AN ACCIDENT □ YES □ NO (IF YES, PLEASE COMPLETE BOTH SIDES)

PATIENT DATA

WORK PHONE (____) _____

NAME _____ HOME PHONE (____) _____

CELL PHONE (____) _____

E-MAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYED BY _____ SS #_____

NAME OF NEAREST RELATIVE _____ PHONE NUMBER (___) _____

NAME OF WIFE OR HUSBAND _____ OCCUPATION _____

EMPLOYER _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS _____

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION _____

MEDICAL HISTORY (If any of the following are relevant to your medical history please √ the accompanying box.)

□ CANCER	□ MUSCULAR DYSTROPHY	□ RHEUMATIC FEVER
□ POLIO	□ MULTIPLE SCLEROSIS	□ SCARLET FEVER
□ TUBERCULOIS	□ CONVULSIONS	□ NERVOUSNESS
□ HIGH BLOOD PRESSURE	□ EPILESPY	□ ASTHMA
□ HEART TROUBLE	□ CONCUSSION	□ DIGESTIVE DISORDERS
□ DIABETES	□ DIZZINESS	□ SINUS TROUBLE
□ HEPATITIS	□ ARTHIRITIS	□ BACKACHES
□ GERMAN MEASLES	□ NEURITIS	□ NUMBNESS
□VENEREAL DISEASE	□ RHEUMATISM	□ ANEMIA

DESCRIBE THE OPERATIONS YOU HAVE HAD: _____ WHEN? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? □ YES □ NO

DESCRIBE CONDITION _____DATE OF LAST PHYSICAL EXAM _____

NAME OF PRIMARY CARE PHYSICIAN _____ NAME OF CLINIC _____

ARE YOU ON ANY MEDICATIONS EITHER PRESCRIPTION OR OVER THE COUNTER? □ YES □ NO IF YES, WHAT KIND?

_____

ARE YOU ALLERGIC TO ANY MEDICATION? □ YES □ NO IF YES, WHAT KIND? _____

WOMEN- ARE YOUR PREGNANT? □ YES □ NO DATE OF LAST MENSTRUAL PERIOD?_____

FAMILY HISTORY OF BACKTROUBLE, HEADACHES, SCOLIOSIS, PINCHED NERVES ? _____

INSURANCE DATA (Clinic policy requires payment arrangements be made on the first visit)

DO YOU HAVE INSURANCE? □ YES □ NO COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE _____

SPOUSE'S INSURANCE _____ _____

DO YOU HAVE A HEALTH SAVINGS ACCOUNT (HSA)? □ YES □ NO

DO YOU HAVE A FLEXIBLE SPENDING ARRANGEMENT (FSA)? □ YES □ NO

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

DATE OF ACCIDENT_____ HOUR OF ACCIDENT _____AM PM

TYPE OF ACCIDENT: □ WORK RELATED □ TRAFFIC □ OTHER

WORK RELATED ACCIDENT
WAS ANY EQUIPMENT, MACHINERY, AND/OR OBJECT RELATED TO ACCIDENT? WHAT KIND? _____

WAS ACCIDENT REPORTED TO SUPERVISOR AND/OR EMPLOYER: □ YES □ NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? □ YES □ NO

TRAFFICENT ACCIDENT
WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT? □ TRUCK □ CAR □ MOTORCYCLE □ OTHER

WERE YOU □ DRIVER □ PASSENGER □ PEDESTRIAN?

I F A PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE CAR. _____

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? □ YES □ NO MPH? _____

DID YOUR VEHICLE HIT OTHER VEHICLE(S)? □ YES □ NO WHERE? _____

DID OTHER VEHICLE(S) HIT YOUR VEHICLE? □ YES □ NO WHERE? _____

WAS THE ACCIDENT REPORTED TO THE POLICE DEPARTMENT □ YES □ NO

WERE TRAFFIC CITATIONS ISSUED? □ YES □ NO TO WHOM? _____

DESCRIBE THE ACCIDENT INCLUDING CAUSE(S) AND SURROUNDING CIRCUMSTANCES _____

_____

_____

PRESENT COMPLAINT

□ HEADACHE
□ HEAD SEEMS TOO HEAVY
□ HEAD & SHOULDER TIRED & HEAVY
□ MENTAL DULLNESS
□ LOSS OF MEMORY
□ EQUILIBRIUM PROBLEMS
□ DIZZINESS
□ FAINTING
□ TREMORS
□ PALPITATION
□ NECK PAIN
□ NECK STIFFNESS
□ NECK MOTION RESTRICTED
□ UPPER BACK PAIN/STIFFNESS
□ MID BACK PAIN/STIFFNESS
□ LOW BACK PAIN/STIFFNESS
□ PINS & NEEDLES IN ARMS/LEGS
□ NUMBNESS IN FINGERS, ARMS,LEGS
□ CHEST PAIN
□ SHORTNESS OF BREATH
□ EYE STRAIN
□ PAIN BEHIND EYES
□ EYES SENSITIVE TO LIGHT
□ EYES LOSS OF FOCUS
□ DOUBLE VISION
□ EARS BUZZING/RINGING
□ LOSS OF TASTE
□ LOSS OF SMELL
□ SINUS TROUBLE
□ EXTREME NERVOUSNESS
□ TENSION
□ IRRITABILITY
□ ANXIETY
□ EXTREME FATIGUE
□ INSOMNIA
□ NEURITIS
□ FACE FLUSHED
□ FACE PALE
□ EXCESS PERSPIRATION
□ DIGESTIVE DISORDERS
□ NAUSEA, VOMITING
□ DIARRHEA
□ CONSTIPATION
□ DEPRESSION
□ SWOLLEN _____
□ FEET/HANDS COLD
□ DIFFICULTY IN PROLONGED CAR RIDING

DIFFICULTY IN EXCESSIVE □ STANDING □ WALKING □ RIDING □ BENDING
□ NECK, LOW BACK PAIN & STIFFNESS UPON RISING
□ PAIN RADIATING INTO □ NECK □ BASE OF SKULL □ SHOULDER □ ARMS □ HIPS □ LEGS
DID YOU REQUIRE POST: ACCIDENT HOSPITALIZATION? □ YES □ NO IF SO, WHERE?_____
HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? □ YES □ NO

SYMPTOMS OTHER THAN ABOVE _____

_____

_____

_____