

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

1 PATIENT INFORMATION		clinic id	date
last name	first name	m.i.	

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? yes no

What services interest you? (mark all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> injury prevention | <input type="checkbox"/> treatment for pain | <input type="checkbox"/> patient education classes |
| <input type="checkbox"/> balance and coordination training | <input type="checkbox"/> spinal and body alignment | <input type="checkbox"/> body composition counseling |
| <input type="checkbox"/> range of motion, mobility, or flexibility therapy | <input type="checkbox"/> strengthening and stamina exercise | <input type="checkbox"/> nutritional and supplement counseling |
| <input type="checkbox"/> other: _____ | | |

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? dull/achy sharp numb tingling burning cold

How often do you experience the **primary** complaint? constantly daily weekly monthly yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

- | | | | | | | | | | |
|--------------------------------|----------------------------|--|--|--|--|--|---|--|--|
| 1 no pain or discomfort | 2 slight discomfort | 3 pain that does not affect my activity | 4 pain that affects my daily activities | 5 pain that prevents performing my daily activities | 6 pain that limits my work schedule | 7 pain that prevents working at all | 8 pain that prevents working and all personal activity | 9 pain that keeps me bed ridden | 10 pain that causes thoughts of suicide |
|--------------------------------|----------------------------|--|--|--|--|--|---|--|--|

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

2 _____	4 _____
3 _____	5 _____

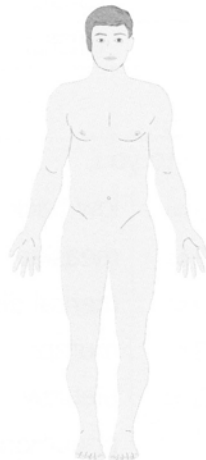
Do you have any other condition other than what brings you here?

yes no

If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right.

Include any descriptors or comments, concerning your health complaints that were not mentioned above.



6 INJURIES

patient name

List any auto collisions that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any job injuries that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any sports injuries that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any other injuries caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Have you had knee or hip replacement surgery?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have a pacemaker?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have any other implantable medical devices in your body?	<input type="checkbox"/> yes	<input type="checkbox"/> no

Mark all of the following procedures as they pertain to you.

vaccinations	<input type="checkbox"/> yes	<input type="checkbox"/> no	tubes in ears	<input type="checkbox"/> yes	<input type="checkbox"/> no	rectal surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
tonsillectomy	<input type="checkbox"/> yes	<input type="checkbox"/> no	appendectomy	<input type="checkbox"/> yes	<input type="checkbox"/> no	sinus surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
gall bladder removal	<input type="checkbox"/> yes	<input type="checkbox"/> no	female/male surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	hernia surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
back surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no				thyroid surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
						stomach surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? yes no Were you ever knocked unconscious? yes no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? yes no

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1 PATIENT INFORMATION		clinic id	date	
last name		first name		m.i.
age	date of birth	social security #	sex	<input type="checkbox"/> male <input type="checkbox"/> female

Are you here because you were involved in a vehicle collision? yes no

Are you here because you were injured at your place of employment? yes no

Are you here because you were involved in another type of accident? yes no

Who is responsible for this account?

Will you be using health insurance to supplement payment to our office*? yes no

* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

2 INSURANCE COVERAGE				
type of insurance				
<input type="checkbox"/> employee group health plan	<input type="checkbox"/> personal health insurance	<input type="checkbox"/> health savings account	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
<input type="checkbox"/> personal injury	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> TRICARE/CHAMPUS	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> FECA
primary insurance company		primary ins ID#	primary ins group#	
secondary insurance company		secondary ins ID#	secondary ins group#	

3 INSURED INFORMATION		Are the insured and patient the same person? <input type="checkbox"/> yes <input type="checkbox"/> no		If YES, do not complete section 3.
last name		first name		m.i.
street				
city		state	zip	
age	date of birth	social security #	sex	<input type="checkbox"/> male <input type="checkbox"/> female
relationship to insured <input type="checkbox"/> spouse <input type="checkbox"/> dependent <input type="checkbox"/> Other _____				

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you - supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges before the associated procedure or service is performed
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered

patient or guardian signature

date

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1 PATIENT CONTACT		clinic id	date
last name		first name	m.i.
preferred to be called			
street			
city		state	zip
home phone		mobile phone	
work phone		e-mail	

2 PATIENT PERSONAL		age	date of birth	social security #	sex	<input type="checkbox"/> male	<input type="checkbox"/> female
status		<input type="checkbox"/> single	<input type="checkbox"/> married	<input type="checkbox"/> partnered	<input type="checkbox"/> widowed	<input type="checkbox"/> separated	<input type="checkbox"/> divorced

3 EMERGENCY CONTACT		name	home phone
relationship			work phone

4 SPOUSE OR GUARDIAN		last name	first name	m.i.
employer name				
work phone		date of birth	social security #	

5 PATIENT EMPLOYMENT		employer name	occupation
street			
city		state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

patient or guardian signature

date