PATIENT INFORMATION

Name _____ Date_____

Address _____ City _____ State _____ Zip_____

Cell Phone(____)_____Email _____

Sex ❑M ❑F Age _____ Date of Birth ___/___/_____ Marital Status: ❑S ❑M ❑D ❑W

# of Children____ Your Occupation_____

Who should we contact incase of an emergency?_____ Phone:_____

What is the purpose of this visit?_____

Where is the pain? _____ When did it start?_____

What where you doing when you first noticed it? _____

When do you feel it most? ❑AM ❑PM ❑Standing ❑Sitting ❑Walking ❑Laying Down

Was this caused by an accident? ❑Yes ❑No Date of Accident ___/___/___

What type of accident? ❑Auto ❑Work ❑Home ❑Other_____

Have you been to a chiropractor before? ❑Yes ❑No How did you hear about us?_____

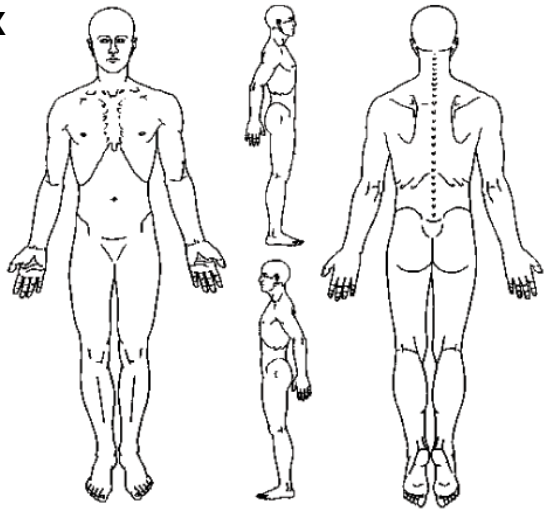
PAIN DISABILITY INDEX

On the Diagram to the right, please indicate where you are experiencing pain or other symptoms.

A = Ache **B** = Burning **N** = Numbness

P = Pins & Needles **S** = Stabbing

O = Other



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE SLIGHT MODERATE SEVERE

Do you suffer from any of the following conditions? (check all that apply)

❑ Allergies	❑ Dizziness	❑ Headaches
❑ Arthritis	❑ Digestive problems	❑ Heartburn/acid reflux
❑ Asthma	❑ Depression	❑ Jaw problems
❑ Arm/shoulder pain	❑ Ears ringing	❑ Low back pain
❑ Blurred vision	❑ Fatigue	❑ Leg pain
❑ Carpal tunnel	❑ Foot/toe numbness	❑ Mid back pain
❑ Diabetes	❑ Gout	❑ Neck pain
❑ Difficulty sleeping	❑ Hand/finger numbness	❑ Urinary tract infections

PAYMENT IS EXPECTED AT THE TIME OF VISIT

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I Authorize the use of this signature on all insurance submissions.

Patient Name: _____ Signature: _____ Date: _____Parent or Guardian: _____ Signature: _____ Date: _____