



PATIENT INFORMATION

Date: _____

Name: _____ Sex _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip _____

CellPhone: _____ Home Phone: _____ Work Phone: _____

email: _____ Social Security # _____

____ Married ____ Single ____ Widowed ____ Divorced ____ Separated - Spouses Name _____

Where are you Employed? _____ Your days off: _____

Emergency contact: _____ Phone: _____

Who is responsible for your bill? ____ Self ____ Spouse ____ Employer ____ Insurance

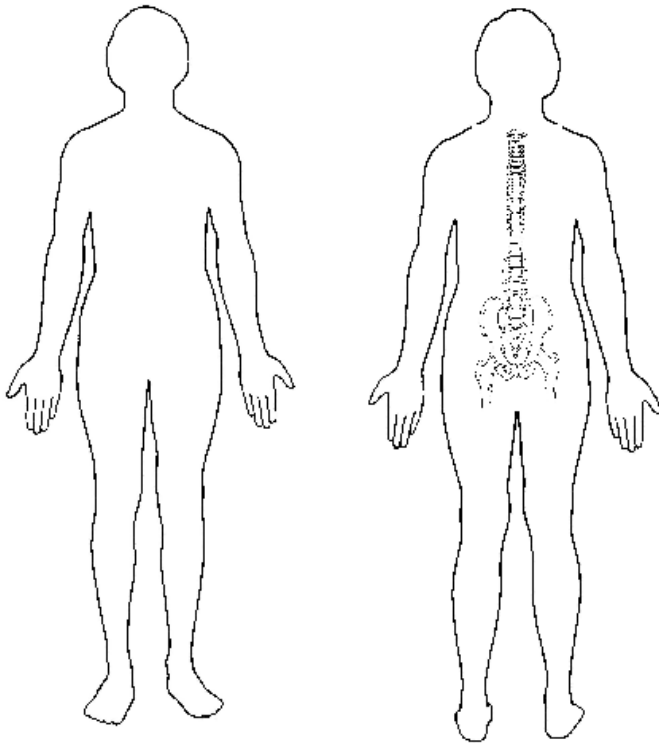
Name of Company and Address : _____

If you are in pain, please mark the exact location of your pain on the diagram below.

MAJOR COMPLAINTS

(Symptoms causing you to seek treatment)

Also described the type and frequency of your pain as well as any activity which brings on or aggravates the pain.



How did the condition develop? (What caused it? How did it start?) _____

When was the very first time you were aware of this problem? _____

Have you ever had this problem or similar problem before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when and what were your results? _____

Has this problem been getting better, worse or staying the same? _____

Is there anything you do that makes your condition worse? _____

How has this condition affected your life?

Home life _____ Occupational life _____

Recreational life _____ Rest & Sleep life _____

Have you ever been in an automobile accident? ___ past year ___ past 5 years ___ over 5 years ___ Never

ANY ACCIDENTS, FALL, ECT THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

What surgery has been done? _____

Are you pregnant? ___ Yes ___ No

DRUGS YOU NOW TAKE: ___ Nerve pills ___ Pain killer ___ Muscle Relaxer ___ "Pep" pills ___ Insulin

___ Tranquilizers ___ Birth Control Pills ___ Other _____

ANY CHIROPRACTORS CONSULTED IN THE PAST? _____

Dates Consulted: _____ For what problem? _____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of the clinic.

Patient's signature _____ Print Name _____

IF YOU ARE AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ Hour: ___ AM ___ PM Location: _____

How did accident occur? ___ Auto accident ___ On-the-job injury ___ Other _____

If NOT an auto collision, please describe the circumstance: _____

Did you report the injury to your foreman or employer? ___ Yes ___ No

If auto accident, were you? ___ Driver ___ Passenger ___ Pedestrian; Were you wearing your seatbelt? ___ Yes ___ No

If auto collision, were you struck from: ___ Behind ___ Right side ___ Left side ___ Front ___ Auto was parked

Did your car strike the other involved? ___ Yes ___ No; Did the other car strike yours? ___ Yes ___ No ___ Unknown

As a result of the accident, were you ticketed? ___ Yes ___ No; Was the driver of the other car cited? ___ Yes ___ No

List the extent of the injuries as you know them: _____

Did you require post-accident hospitalization? ___ Yes ___ No Have you lost any days of work ___ Yes ___ No

Check the symptoms you have had since the accident: ___ Headache ___ Neck pain ___ Neck stiff

___ Back pain ___ Sleeping problem ___ Tension ___ Nervousness ___ Ear Ring ___ Loss of smell or taste

___ Hands/feet cold ___ Shortness of Breathe ___ Fainting spells ___ Dizziness

Symptoms other than above: _____

Have you been contacted by an Insurance Adjuster / Co. Representative regarding this claim? ___ Yes ___ No

If YES their Name & Phone #: _____

Name of YOUR Insurance Company: _____

Name of Other Insurance Company: (if any) _____

Do you have an attorney? ___ Yes ___ No Name / Address / Phone of Attorney _____