BACK IN LINE CHIROPRACTIC

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Employer _____

Referred By _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co
& Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co
& Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. 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 the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to call _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____

Home _____ Work _____

ACCIDENT INFORMATION

Is condition due to an accident Yes No Date _____

Type of accident Auto Work Home Other

To whom was accident reported?
Auto Insurance Employer Worker's Comp Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

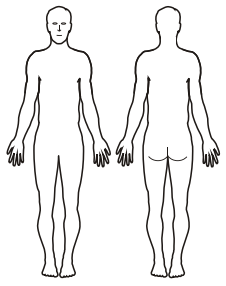
Type of Pain: Sharp Dull Throbs Numb Aches Shooting Burns
Tingles Cramps Stiffness Swelling Other

How often do you have this pain? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Mark picture with an X where symptoms occur



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic Services None Other_____

Name and address of other doctor(s) who have treated you for your condition_____

Date of last:
Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Circle Yes or No to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Emphysema	Yes	No	Miscarriage	Yes	No	Scarlet Fever	Yes	No
Alcoholism	Yes	No	Epilepsy	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Allergy Shots	Yes	No	Fractures	Yes	No	Multiple Sclerosis	Yes	No	Suicide Attempt	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No				Thyroid Problems	Yes	No
Anorexia	Yes	No	Goiter	Yes	No	Mumps	Yes	No	Tonsilitis	Yes	No
Appendicitis	Yes	No	Gonorrhea	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Pacemaker	Yes	No	Tumors, Growths	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Parkinson's Disease	Yes	No	Typhoid Fever	Yes	No
Bleeding Disorders	Yes	No	Hepatitis	Yes	No	Pinched Nerve	Yes	No	Ulcers	Yes	No
Breast Lump	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Vaginal Infections	Yes	No
Bronchitis	Yes	No	Herniated Disk	Yes	No	Polio	Yes	No	Venereal Disease	Yes	No
Bulimia	Yes	No	Herpes	Yes	No	Prostate Problem	Yes	No	Whooping Cough	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No	Prosthesis	Yes	No	Other_____		
Cataracts	Yes	No	Kidney Disease	Yes	No	Psychiatric Care	Yes	No			
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No			
Chicken Pox	Yes	No	Measles	Yes	No	Rheumatic Fever	Yes	No			
Diabetes	Yes	No	Migraine Headaches	Yes	No						

Exercise

None
Moderate
Daily
Heavy

Work Activity

Sitting
Standing
Light Labor
Heavy Labor

Habits

Smoking Packs/Day_____
Alcohol Drinks/Week_____
Coffee/Caffeine Drinks Cups/Day_____
High Stress Level Reason_____

Are you pregnant? Yes No Due Date_____

Injuries/Surgeries you have had — Description — Date

Falls_____
Head Injuries_____
Broken Bones_____
Dislocations_____
Surgeries_____

MEDICATIONS — ALLERGIES — VITAMINS/HERBS/MINERALS

_____ _____ _____
_____ _____ _____
Pharmacy Name_____ _____ _____
Pharmacy Phone_____ _____ _____