OFFICE USE ONLY 1. Patient Number_____ 2. Date_____ 3. Claim number_____

4. First Name_____ 5. M.I_____ 6. Last Name _____

Address_____ City_____ State_____ Zip_____

Home ph:_____ Cell ph:_____ E- mail:_____

SSN_____ Date of Birth_____ 7.Age_____ Height_____ Weight_____

8. □ Male □ Female □ Single □ Married □ Divorced #of children _____ Name of spouse(or parent)_____

Employer_____ Address_____

City_____ State_____ Zip_____ Wk Ph._____ Occupation_____

Whom may we thank for referring you to us? _____

Have you ever had Chiropractic care before? Y / N if yes, when?_____ Doctors Name_____

Please List Your Chief Complaint:_____ **Date Started:**_____

9. Is this condition due to: **A.** Auto Accident **B.** Work Injury **C.** Other Accident **D.** Unknown Cause **E.** Illness

10. Are the symptoms **A.** Improving **B.** Getting Worse **C.** About the same **D.** Intermittent (Come and Go)

11. Which activities aggravate your condition: **A.**Standing **B.**Walking **C.**Sitting **D.**Lying **E.**Bending **F.**Lifting **G.**Twisting **H.**Coughing

12. Have you had these symptoms before? Y / N If so when?_____

13. Have you seen another doctor for this condition? **A** M.D **B** Chiropractor **C** Osteopath **D** Acupuncturist **E** Dentist **F** Podiatrist

Doctors Name_____ Date Consulted_____ Diagnosis_____

If the injury is to due to an auto accident what is the name of your insurance company? _____

Policy Holder Name_____ Claims Address_____

Policy and/or Claim Number_____ Telephone Number_____

What was the date of the auto accident?_____ How many passengers were in the vehicle with you?_____

Involved Parties Name_____ Insurance Company_____

Attorney Name_____ Telephone Number_____

Address_____ City_____ State_____ Zip_____

If this was due to a work injury what is the name of the Claims Adjuster?_____Claim Number_____

Have you ever had any surgeries or hospitalizations? Y / N If yes please list:_____

Please list any injuries or illnesses that you have had that are not listed above:_____

Please list any medications that you are currently taking (over the counter/ Prescriptive) □ Aspirin/Tylenol □ Pain Killers

□ Muscle Relaxers □ Insulin □Tranquilizers □Birth Control □Others_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. In the event of default I promise to pay legal interest on the indebtedness together with such collection cost and reasonable attorney fees as may be required to effect collection.

Patient Signature_____Date_____