Patient Information

Date: _____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____
Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Financial Office Policies

1. Any and all services, supplements and in office testing will be the patient's responsibility.
2. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
3. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
4. This office accepts MasterCard, Visa, Discover Card, AMEX, personal checks and cash.
5. If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.
6. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.
I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____/_____/_____
Patient Signature or Responsible Party Date

Primary Health Concerns

Who is your primary care physician? (Doctor and/or practice) _____

PLEASE ADDRESS WHAT BRINGS YOU TO OUR OFFICE:

Health concerns list According to severity	Rate of Severity 1=Mild 10= Severe	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Please check to indicate if you are currently or have ever experiencing any of the following conditions:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Ankle Swelling
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arm/Hand Pain
- ❑ Arthritis
- ❑ Asthma
- ❑ Asthma
- ❑ Back Pain/Stiffness
- ❑ Bleeding Disorders
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Cold Feet/Hands
- ❑ Cold Sores
- ❑ Cold Sweats
- ❑ Constipation
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fatigue
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Hair Loss
- ❑ Headaches
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herniated Disc
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Jaw Problems
- ❑ Kidney Disease
- ❑ Leg/Knee Pain
- ❑ Light Bothers Eyes
- ❑ Liver Disease
- ❑ Loss of Memory
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Low Body Temp
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain/Stiffness
- ❑ Nervousness
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pinched Nerve
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
- ❑ Strep Throat
- ❑ Stroke
- ❑ Sudden Weight Loss
- ❑ Suicide Attempt
- ❑ Tension
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tubes in Ears
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- ❑ Arthritis _____
- ❑ Autoimmune _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ Neurological Diseases_____
- ❑ Other _____

Received A Diagnosis For ANY Condition By Another Health Care Provider? Y N

If Yes, What Was The Diagnosis? _____

Who Provided the Diagnosis**?**_____

Medication Name	Dosage	Reason

Supplement Name/Brand	Dosage	Reason

Please list any allergies: _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Does your work activity mostly involve?
❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:
Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes ____ packs/day

Have you ever been exposed to mold? Yes _____ No _____

Have you ever been exposed to chemicals (work, pesticides, etc.)? Yes _____ No ____

Sleep/Rest:

Average number of hours you sleep: _____ more than 10 _____ 8 to 10 _____ 6 to 8 _____ less than 6

Do you have trouble sleeping? Yes_____ No _____

Do you have problems falling asleep? Yes_____ No _____

Do you have problems staying asleep Yes_____ No _____

Do you feel rested upon awakening? Yes_____ No_____

Do you have problems with insomnia? Yes _____ No _____

Do you snore? Yes_____ No _____

Do you use sleeping aids? Yes _____ No _____

Is there anything else you would like our office to know?

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____

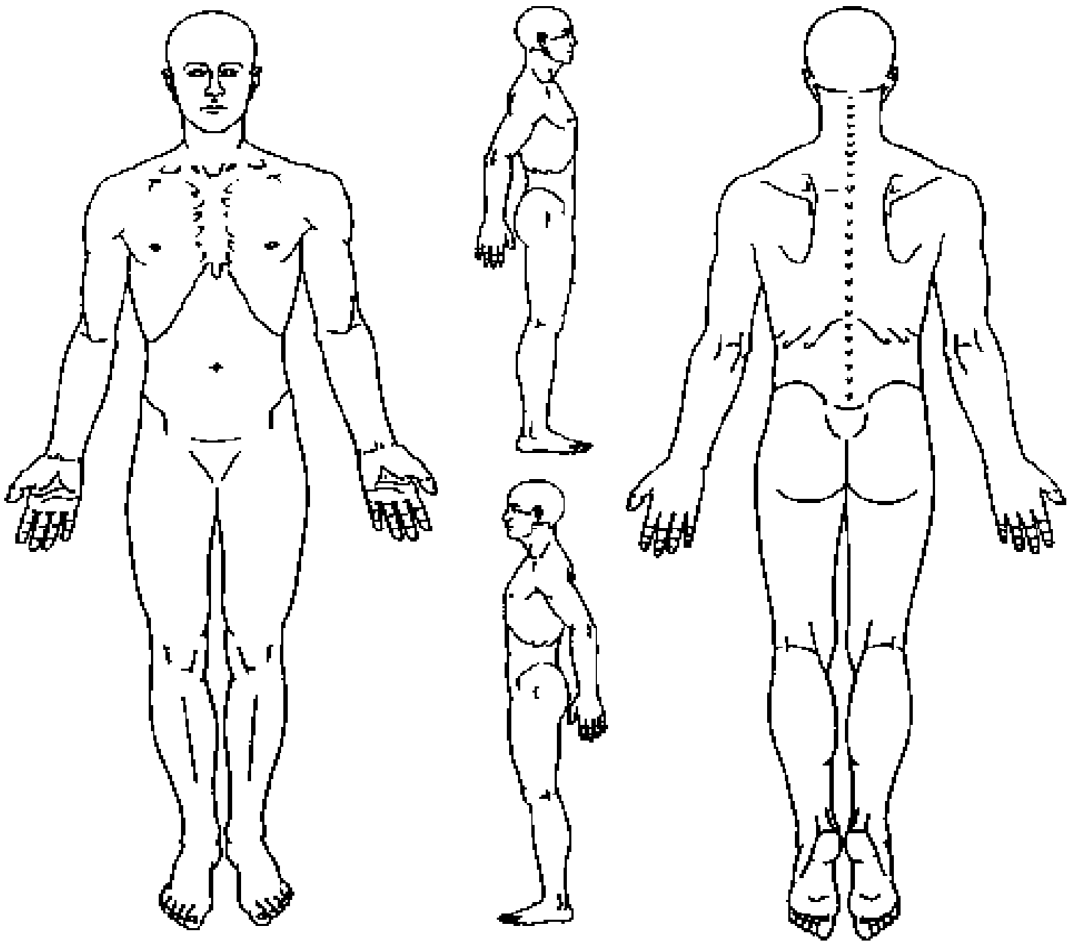
Patient's Signature Date

PAIN DIAGRAM

PATIENT'S NAME _____

On the diagram below, please indicate where you are experiencing pain or other symptoms. Use the following to describe your symptoms:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing O = Other



Please rate your current level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's Signature: _____ Date: _____

How does this condition affect your daily activities?

ACTIVITIES OF DAILY LIVING

	No effect	Mildly painful (Can do)	Moderately Painful (Limited)	Severely Painful (Unable to perform)
Bending				
Carrying groceries				
Changing postitions (Sit to stand)				
Climbing stairs				
Driving				
Extended Computer Use				
Household chores				
Kneeling				
Lifting (over 10 lbs)				
Hobbies or Sports				
Reading (concentration)				
Bathing				
Getting Dressed				
Sexual activities				
Sleeping				
Sitting				
Standing				
Walking				
Yard Work				