

Date: _____

1

Patient Information

Name: _____
(First) (Initial) (Last) (Name called by)

Address: _____

City _____ State _____ Zip _____

Birthday: _____ Age: _____ Male Female

Social Security # _____/_____/_____

Occupation: _____

Employer: _____

Parents Name (if a minor): _____

Single Married Divorced Widowed Separated

Spouse's Name: _____

of Children: _____ Name(s) _____

Referred By: _____

2

Payment Plan Options

I understand the "Policy on Fee Schedules & Payments" which has been explained to me.

I choose the following payment plan (please check one):

_____ I do not have health insurance coverage for chiropractic care in this office and agree to pay for treatment provided at the time of service.

_____ I wish to utilize my health insurance coverage and understand that deductibles and copays are due at the time services are rendered.

_____ I understand that I will receive a discount by purchasing two or more visits in advance of treatment. These packages are not eligible to be submitted to insurance.

_____ I am a Medicare-eligible patient and understand that I will pay for out of pocket costs at the time of service.

3

Accident Information

Is your condition due to an accident? No Yes Date: _____

Type of accident? Automobile Work Home Other

To whom have you reported the accident?

Insurance Worker's Comp Employer Other

Attorney Name (If applicable) _____

4

Contact Information

Home Phone: _____

Cell Phone: _____

Work Phone: _____ Ext.: _____

Email: _____

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Patient Condition

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes No

Is this problem: Constant Comes and Goes

How does it feel? Burning Sharp Shooting Dull Aching Stiff
 Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:
(no pain) **0 1 2 3 4 5 6 7 8 9 10** (severe pain)

What makes your condition better?

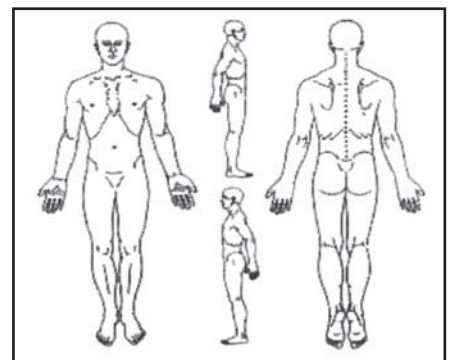
What makes your condition worse?

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/movements that are painful to perform:

Sitting Standing Walking Bending Lying Down Driving Reading Getting Up

Please mark where it hurts



6

Health History

What other treatments have you had for this condition?

- Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery

Name of other doctors who have treated you for this condition: _____

Describe the other doctor's treatment for your condition: _____

Previous Chiropractic care? No Yes Date _____ Local Out of state _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ MRI/CT-Scan _____

List any medications you are taking _____

Vitamins / Herbs / Minerals _____

Females: Are you pregnant? Yes No Beginning of last menstrual cycle _____

Check any of the following conditions you have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bladder/Kidney Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Insomnia | <input type="checkbox"/> STD |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Liver/Gall Bladder Problems | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Neurological Problems
(M.S., Alzheimers, Parkinsons) | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Ear Ringing | | |

STRESSORS

- | | |
|---|-------------------|
| <input type="checkbox"/> Smoking | Packs/Day _____ |
| <input type="checkbox"/> Alcohol | Drinks/Week _____ |
| <input type="checkbox"/> Coffee/Caffeine Drinks | Cups/Day _____ |
| <input type="checkbox"/> High Stress Level | Reason _____ |

EXERCISE

- None
 Moderate
 Daily
 Heavy

Have you had any:

Description

Date

Automobile Accidents _____

Surgeries _____

Broken Bones _____

Falls/Head Injuries _____

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Authorization

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. Furthermore, I understand that Abarr Lake Chiropractic and Acupuncture Clinic P. C. will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Furthermore, I understand that balances left unpaid over 30 days will be subject to finance charges in the amount of \$5.00 per month or interest at the rate of 15%. I acknowledge that a copy of the notice of Privacy Practices for Abarr Lake Chiropractic & Acupuncture Clinic, P.C. was made available for my review and records.

Patient Signature

Date