

Name: _____ Date: _____

Insurance

Who is responsible for this account?		Relationship to patient:	
Birth date: ____ / ____ / ____ MM DD YY	SS #: ____ - ____ - _____		
Insurance company name:		Group number:	ID #:
Is patient covered by additional insurance? <input type="checkbox"/> yes <input type="checkbox"/> no	Subscriber's name: _____ First Last		Birth date: ____ / ____ / ____ MM DD YY
SS #: ____ - ____ - _____	Insurance company name:	Group number:	ID #
<p>Assignment and Release I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and deterring insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.</p>			
_____ Signature of patient, parent, guardian or personal representative		_____ Print name of patient, parent, guardian, or personal representative	
_____ Date		_____ Relationship to patient	

Patient Condition

Reason for your visit?		When did your symptoms appear?	
Is this condition getting progressively worse? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): 1 2 3 4 5 6 7 8 9 10		
Type of pain: <input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> throbbing <input type="checkbox"/> numbness <input type="checkbox"/> aching <input type="checkbox"/> burning <input type="checkbox"/> shooting <input type="checkbox"/> cramping <input type="checkbox"/> tingling <input type="checkbox"/> swelling <input type="checkbox"/> stiffness <input type="checkbox"/> other	How often do you have this pain?		
Is it constant or does it come and go?	Does it interfere with your (check all that apply): <input type="checkbox"/> sleep <input type="checkbox"/> work <input type="checkbox"/> recreation <input type="checkbox"/> daily routine	Activities that are painful to perform (check all that apply): <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> bending <input type="checkbox"/> walking <input type="checkbox"/> lying down	
Treatment you are receiving or have received for this condition:			
<input type="checkbox"/> Medical Care _____		<input type="checkbox"/> Chiropractic Care _____	
<input type="checkbox"/> Physical Therapy _____		<input type="checkbox"/> Other _____	

Name: _____

Date: _____

Review of Systems

	No	Yes		No	Yes		No	Yes
Constitutional			Respiratory			Eye		
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Far sighted	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	Near sighted	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, and Throat		
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	Excessive belching	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Excessive gas	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric			Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Ear noise	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal			Difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Bloated abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Gum trouble	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Mid back pain	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Cardiovascular			Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Hardening of arteries	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin			Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Slow heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hives/allergy	<input type="checkbox"/>	<input type="checkbox"/>	Neurological		
Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
			Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
						Coordination difficulty	<input type="checkbox"/>	<input type="checkbox"/>

Habits

	Yes	No	If yes, please describe:
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: <input type="checkbox"/> 0-1/2 <input type="checkbox"/> 1/2-1 <input type="checkbox"/> 2 or more How long? _____
Alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	Number of drinks per day _____ # of drinks per week _____
Other drug use (street drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Type _____

Medications

Please list all currently used medications. Include prescription and non-prescription drugs.

Name: _____ Date: _____

Allergies

Please list all known allergies, especially to medications.

Surgeries/Operations

YEAR	BODY REGION	PROCEDURE

Family History

Please mark relative's current age or age at time of death. Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy - Asthma	Alcohol abuse	Arthritis - Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (describe)	
Father																			
Mother																			
Brothers & Sisters																			

Prior Auto Accidents/Work Injuries

YEAR	AUTO/WORK COMP	BODY REGION(S)	LENGTH OF TREATMENT

Medical Illnesses

List current and past illnesses not mentioned above.
