

Patient Name: _____ Birthdate: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: _____ Cell Phone: _____ Social Security #: _____
 Occupation: _____ Employer: _____ Work Phone: _____

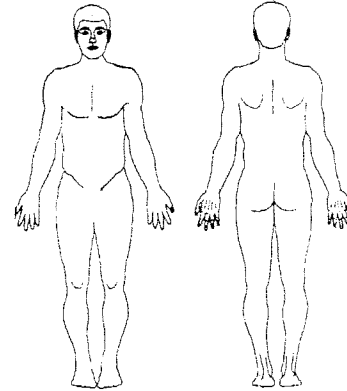
Please provide your EMAIL: _____

If you prefer not to have any information emailed to you, please leave the email blank.

Subscriber Name: _____ Health Plan: _____
 Subscriber ID#: _____ Group#: _____ Spouse Name: _____
 Spouse Employer: _____ Spouse Contact Number: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:



Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____

Current Complaint (how do you feel today?):										
0	1	2	3	4	5	6	7	8	9	10
No Pain						Extreme Pain				

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Can you perform your daily activities? Yes No (Explain) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes **Date(s) taken:** _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you:

- | Past | Present | Condition | Past | Present | Condition |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Recent serious infection | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS, HEP B or HEP C (circle) | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Spinal Pain <input type="checkbox"/> Low <input type="checkbox"/> Mid <input type="checkbox"/> Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ Type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis <input type="checkbox"/> Osteo <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness / Fainting (circle one) | <input type="checkbox"/> | <input type="checkbox"/> | Trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin / Buttocks | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use (Packs/day) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic or other aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries / Medications: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer / Tumor _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis / Osteopenia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular / Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

CONTINUED HEALTH HISTORY

PAST PRESENT

- Pacemaker / Heart Surgery
- Heart Attack
- Congenital Heart Defect
- Mitral Valve Prolapse
- Heart Murmur
- Artificial Valves
- Artificial Bones / Joints
- Kidney Problems
- Hepatitis
- Psychiatric Difficulties
- Anemia
- Rheumatic Fever

PAST PRESENT

- Drug Abuse
- Low Blood Pressure
- Severe / Frequent Headaches
- Venereal Disease
- Shingles
- Tuberculosis
- Emphysema / Glaucoma
- Sinus Problems
- Difficulty Breathing
- Asthma
- Chemotherapy
- Ulcers / Colitis

IN EVENT OF AN EMERGENCY, PLEASE CONTACT:

Person: _____ Relation: _____

Phone #: _____ Alternate Phone #: _____

Medical Doctor: _____ Phone #: _____

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT PAYMENT:

Name: _____ Relation: _____

Billing Address: _____
CITY STATE ZIP

SSN #: _____ D.L.#: _____ Work Phone #: _____

PAYMENT METHOD: CASH CHECK CREDIT / DEBIT CARD _____

I hereby authorize assignment of my insurance rights and benefits to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

INITIALS _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and / or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE Adult Patient Parent or Guardian Spouse Date ____/____/____