

PATIENT INFORMATION

DATE _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PH. _____ MOBILE _____

WORK _____ E-MAIL _____

SEX: M F AGE ____ BIRTHDATE ____/____/____

SINGLE MARRIED WIDOWED SEPARATED DIVORCED

SOCIAL SECURITY NUMBER _____ - ____ - ____

OCCUPATION _____

EMPLOYER _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN:

NAME _____

ADDRESS _____

PHONE _____ FAX _____

MAY WE CONTACT THEM TO UPDATE YOUR CONDITION? Y N

IN CASE OF EMERGENCY, CONTACT

NAME _____ RELATIONSHIP _____

HM ☎ _____ CL ☎ _____

INSURANCE

IF YOU ARE **NOT** THE PRIMARY, PLEASE FILL OUT THE FOLLOWING:

PRIMARY HOLDER'S INFORMATION:

NAME _____

BIRTHDATE ____/____/____ SOC SEC # ____ - ____ - ____

OCCUPATION _____

EMPLOYER _____

RELATIONSHIP TO PATIENT _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO

IF YES, WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE _____

RELATIONSHIP _____ DATE _____

ACCIDENT INFORMATION

IS THIS CONDITION DUE TO AN ACCIDENT? YES NO

IF SO, TYPE OF ACCIDENT: AUTO WORK HOME OTHER

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?

AUTO INSURANCE EMPLOYER WORKER COMP OTHER

ATTORNEY NAME (IF APPLICABLE) _____ PHONE _____

PATIENT CONDITION

REASON FOR YOUR VISIT _____

WHEN DID YOUR SYMPTOMS APPEAR? _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES NO

WHAT PERCENTAGE OF AWAKE TIME DO YOU HAVE THIS PAIN? _____ %

IS THE PAIN CONSTANT COMES AND GOES

DOES THE PAIN INTERFERE WITH YOUR:

WORK SLEEP

DAILY ROUTINE RECREATION

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM:

SITTING STANDING

BENDING LYING DOWN

WALKING

PLEASE LIST ANY INJURIES OR SURGERIES THAT YOU HAVE HAD IN THE PAST:

	DESCRIPTION	DATE
FALLS	_____	_____
HEAD INJURIES	_____	_____
FRACTURES	_____	_____
DISLOCATIONS	_____	_____
SURGERIES	_____	_____

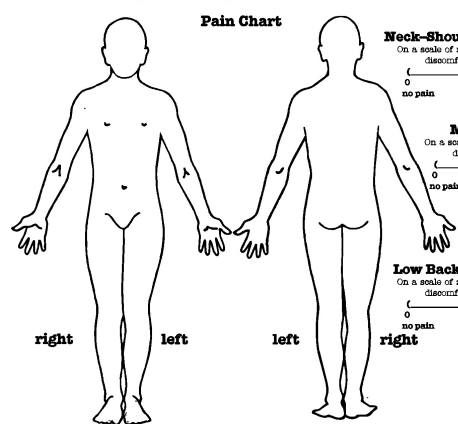
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my discomfort as follows: () / ()
0 no pain 10 severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows: () / ()
0 no pain 10 severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows: () / ()
0 no pain 10 severe pain

HEALTH HISTORY

PARADISE CHIROPRACTIC

HAVE YOU EVER HAD CANCER? NO YES, SPECIFY _____

DOES YOUR PAIN EVER WAKE YOU FROM A SOUND SLEEP? NO YES, LAST OCCURRENCE _____

ARE YOU LOSING WEIGHT NOW WITHOUT TRYING? NO YES, REASON _____

DO YOU COUGH UP BLOOD OR NOTICE ANY IN YOUR STOOL OR URINE? NO YES, LAST OCCURRENCE _____

HAVE YOU HAD ANY LOSS OF BLADDER OR BOWEL CONTROL? NO YES, LAST OCCURRENCE _____

HAVE YOU LOST CONCIOSNESS OR HAD DOUBLE VISION RECENTLY? NO YES, LAST OCCURRENCE _____

ARE YOU TAKING ANY MEDICATIONS OR OVER-THE-COUNTER DRUGS? NO YES, SPECIFY _____

DO YOU HAVE ANY KNOWN ALLERGIES? NO YES, SPECIFY _____

ARE YOU TAKING ANY VITAMINS, HERBS, MINERALS, OR SUPPLEMENTS? NO YES, SPECIFY _____

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION?

MEDICATIONS CHIROPRACTIC SERVICES PHYSICAL THERAPY

SURGERY NONE OTHER _____

NAME AND ADDRESS OF OTHER DOCTOR(S) WHO HAVE TREATED YOU FOR YOUR CONDITION

1. _____ D.C. M.D. OTHER _____

DOCTOR'S NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE

2. _____ D.C. M.D. OTHER _____

DOCTOR'S NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE

DATE OF LAST: PHYSICAL EXAM _____ SPINAL X-RAY _____ BLOOD TEST _____

 SPINAL EXAM _____ CHEST X-RAY _____ URINE TEST _____

 DENTAL X-RAY _____ MRI/CT SCAN _____ BONE SCAN _____

PLEASE INDICATE WITH A IF YOU HAVE HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> CATARACTS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> STROKE
<input type="checkbox"/> ALCOHOLISM	<input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/> HERNIA	<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> THYROID PROBLEMS
<input type="checkbox"/> ALLERGY SHOTS	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> HERNIATED DISC	<input type="checkbox"/> PARKINSON'S DISEASE	<input type="checkbox"/> TONSILLITIS
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HERPES	<input type="checkbox"/> PINCHED NERVE	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> APPENDICITIS	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> TUMORS, GROWTHS
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> POLIO	<input type="checkbox"/> TYPHOID FEVER
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> FRACTURES	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> PROSTATE PROBLEMS	<input type="checkbox"/> ULCERS
<input type="checkbox"/> BLEEDING DISORDERS	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> MEASLES	<input type="checkbox"/> PROSTHESIS	<input type="checkbox"/> VAGINAL INFECTIONS
<input type="checkbox"/> BREAST LUMP	<input type="checkbox"/> GOITER	<input type="checkbox"/> MIGRAINE HEADACHES	<input type="checkbox"/> PSYCHIATRIC CARE	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> GONORRHEA	<input type="checkbox"/> MONONUCLEOSIS	<input type="checkbox"/> RHEMATOID ARTHRITIS	<input type="checkbox"/> WHOOPING COUGH
<input type="checkbox"/> BULEMIA	<input type="checkbox"/> GOUT	<input type="checkbox"/> MULTIPLE SCLEROSIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> MUMPS	<input type="checkbox"/> SCARLET FEVER	_____

SOCIAL HISTORY

EXERCISE: NONE MODERATE (1-3x/wk) DAILY (4-6x/wk) HEAVY (7x/wk)

WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR

SMOKING: YES NO _____ PACKS/DAY _____

ALCOHOL: YES NO _____ DRINKS/WEEK _____

COFFEE/CAFFEINE DRINKS: YES NO _____ CUPS/DAY _____

HIGH STRESS LEVEL: YES NO _____ REASON _____

ARE YOU PREGNANT? YES NO _____ DUE DATE _____

TAKE BIRTH CONTROL? YES NO _____ KIND AND TYPE _____

DATE OF LAST MENSES: _____

FAMILY HISTORY

DOES YOUR MOTHER OR FATHER HAVE/HAD ANY OF THE FOLLOWING: (PLEASE INDICATE **M** FOR MOTHER, **F** FOR FATHER, OR **B** FOR BOTH)

_____ ARTHRITIS/RHEUMATISM	_____ HIV POSITIVE	_____ OSTEOPOROSIS
_____ HIGH BLOOD PRESSURE	_____ HEART ATTACK	_____ ASTHMA
_____ CANCER	_____ STROKE	_____ EMPHYSEMA
_____ DIABETES	_____ PACEMAKER	_____ KIDNEY DISEASE
_____ FATALITIES/DEATHS	_____ CIRCULATION PROBLEMS	_____ THYROID DISEASE
_____ GENETIC PREDISPOSITIONS	_____ SEIZURES/COVULSIONS	