Form 101
90903

Patient Information Form

Patient Number ______________(**Office Use Only**) 2) Date _____/_____/_____ Claim Number _______________

First Name___________________ M.I.____ Last Name____________________ Phone( )___________________
Street_____________________________ City/Town_________________State________ Zip Code_____________
Age______ Sex______ Birth Date ___/___/___ Marital Status (S M W D) Spouse's Name___________________
Social Security #__________________ Occupation ________________ Employer _______________________
Work Phone ( )_____________ Work Address____
Person Responsible for this account ____
Would you like to receive occasional E-mail from us? (Y/N) E-mail address:_________________________________

❑ I do not have any Medical Insurance. (signature)__________________________________Date___________

Insurance Information: (Group___ Private___ Work/Comp___ Automobile___) Policy#_____________________
Name of Insured__________________ Relationship to Patient__________________ S.S#_______________________
Insurance Co.____ Group #___________________________________
Street _________________________ City/ Town________________________ Zip Code_____________________

What is your major complaint? _________________________ When did this begin? __________________________

Is this condition due to an: A) Auto Accident B) Work Injury C) Slip & Fall D) Unknown Cause E) Illness

Are the symptoms: A) Improving B) Getting Worse C) About the same D) Come and Go

Have you had these symptoms before? (Y / N) If so, when? ___________________________________

Have you seen another doctor for this condition? A) M.D. B) Chiropractor C) Emergency Room D) Acupuncturist

Drs. Name_______________________ Date Consulted___/___/___ Diagnosis_________________________

Drs. Name_______________________ Date Consulted___/___/___ Diagnosis_________________________

Do you or does anyone in your household smoke? (Y / N) ____

Have you had recent weight gain or loss? (Y / N)____

Have you or any family members been diagnosed with: ❑high blood pressure, ❑diabetes, ❑asthma, ❑tumors, ❑other

Have you ever had any surgery? (Y / N) ____

Please list any medication(s) that you are taking. ____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that insurance claims are submitted on my behalf as a courtesy, and it is my responsibility to see that they are paid. I also understand that if I suspend or terminate my care and treatment, the fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest (15%) on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature Date -turn over-

GENERAL SYMPTOMS: (Circle as many as apply)

A) Nervousness B) Irritability C) Fatigue
D) Depression E) Loss of Sleep F) Tension
G) PMS H) Jaw Pain

HEAD: (Circle as many as apply)
Headache – 1) Mild 2) Moderate 3) Severe
How often: (1 2 3 4 5 6) Per (Day/ Wk./ Mo.)
Are they: 1) Sharp 2) Dull
Are they: 1) Constant 2) Intermittent
Where located: 1) Back of Head 2) Forehead 3) Temples
4) Right Side 5) Left Side 6) Behind Eyes
B) Light Headed C) Memory Loss D) Fainting
E) Blurred Vision F) Doubled Vision G) Sensitivity to Light
H) Loss of Balance I) Hearing Loss J) Ringing in Ears

NECK: (Circle as many as apply)
Pain--1) Left Side 2)Right Side 3) Both
Pain Level—1) Mild 2) Moderate 3) Severe
Type of Pain: Burning / Aching / Dull / Sharp / Stabbing
Stiffness / Numbness
Pain increased by: 1) looking down 2) looking up
3) turning head left 4) turning head right.
5) bending neck left 6) bending neck right
or with: typing /writing / reading / working /housework
strenuous activity/driving / sitting / bending /
lifting / twisting/ standing
Pain relieved with: Medication /Aspirin /Tylenol /Motrin
Ice / Heating Pad / Hot Showers / Hot Bath
Massage / Rest / Stretching

SHOULDERS: (Circle as many as apply)
A) Pain in Joint---- 1) Left 2) Right 3) Both
B) Pain Across Shoulder--- 1) Left 2) Right 3) Both
C) Limitation of Movement-1) Left 2) Right 3) Both
D) Tension---- 1) Left 2) Right 3) Both

ARMS: (Circle as many as apply)
A) Pain in Upper Arm---- 1) Left 2) Right 3) Both
B) Pain in Elbow---- 1) Left 2) Right 3) Both
C) Pain in Forearm---- 1) Left 2) Right 3) Both
D) Pins & Needles (Arm)---- 1) Left 2) Right 3) Both
E) Pins & Needles (Forearm)--- 1) Left 2) Right 3) Both
F) Numbness in Arm---- 1) Left 2) Right 3) Both
G) Numbness in Forearm---- 1) Left 2) Right 3) Both

HANDS: (Circle as many as apply)
A) Pain in Wrist---- 1) Left 2) Right 3) Both
B) Pain in Hand---- 1) Left 2) Right 3) Both
C) Pins & Needles (Hand)---- 1) Left 2) Right 3) Both
D) Numbness (Hand)---- 1) Left 2) Right 3) Both

MIDBACK: (circle as many as apply)
A) Pain 1) Left 2) Right 3)Both
Pain Level- 1) Mild 2) Moderate 3) Severe
Pain Type- Sharp / Stabbing / Dull / Ache
B) Muscle Spasm 1) Left 2) Right 3) Both

CHEST: (Circle as many as apply)
A) Chest Pain- 1)Left 2) Right 3) Both
Pain Level- 1)Mild 2)Moderate 3) Severe
B) Pain around ribs 1)left 2) Right 3) Both
Shortness of Breath / Irregular heartbeat

ABDOMINAL SYMPTOMS: (Circle as many as apply)
A) Pain 1) Mild 2)Moderate 3)Severe
B) Nervous Stomach C) Nausea D) Gas E) Constipation
F) Diarrhea G) Heartburn H) Loss of Appetite

LOW BACK (Circle as many as apply)
Pain--1) Left Side 2)Right Side 3) Both
Pain Level- 1) Mild 2) Moderate 3) Severe
Type of Pain: Burning / Aching / Dull / Sharp / Stabbing
Stiffness / Numbness
Pain increased by: 1) bending over 2) leaning back
3) twisting left 4) twisting right.
5) bending left 6) bending right
or with: strenuous activity / driving / sitting / standing
walking / lifting / housework
Pain relieved with: Medication /Aspirin /Tylenol /Motrin
Ice / Heating Pad / Hot Showers / /Hot Bath
Massage / Rest / Stretching

HIPS AND LEGS: (Circle as many as apply)
A) Pain in Buttocks- 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
B) Pain in Hip Joint 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
C) Pain Down Leg- 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
Location- 1) Front 2) Back 3) Side
Pain radiates to 1) Knee 2) Calf 3) Foot

KNEE:
A) Pain Level 1)Mild 2)Moderate 3) Severe
B) Location 1) Left 2) Right 3) Both
C) Location 1) Front 2) Back 3) Side

FEET: (Circle as many as apply)
A) Ankle Pain 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
B) Swollen Ankle 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
C) Foot Pain 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
D) Numbness of Feet 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
E) Swollen Feet 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe
F) Cramps 1) Left 2) Right 3)Both
Pain Level 1)Mild 2)Moderate 3) Severe

Comments or Other Information: