

PATIENT INFORMATION

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Cell Phone(____) _____ Email _____
Sex M F Age _____ Date of Birth ___/___/___ Marital Status: S M D W
of Children _____ Your Occupation _____
Who should we contact incase of an emergency? _____ Phone: _____
What is the purpose of this visit? _____
Where is the pain? _____ When did it start? _____
What were you doing when you first noticed it? _____
When do you feel it most? AM PM Standing Sitting Walking Laying Down
Was this caused by an accident? Yes No Date of Accident ___/___/___
What type of accident? Auto Work Home Other _____
Have you been to a chiropractor before? Yes No How did you hear about us? _____

PAIN DISABILITY INDEX

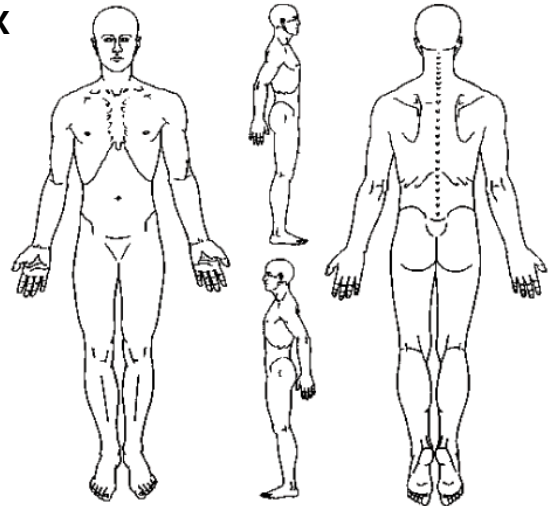
On the Diagram to the right, please indicate where you are experiencing pain or other symptoms.

A = Ache B = Burning N = Numbness
P = Pins & Needles S = Stabbing
O = Other

PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10
NONE SLIGHT MODERATE SEVERE



Do you suffer from any of the following conditions? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Heartburn/acid reflux |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Jaw problems |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Foot/toe numbness | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Urinary tract infections |

PAYMENT IS EXPECTED AT THE TIME OF VISIT

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 payment of benefits. I Authorize the use of this signature on all insurance submissions.

Patient Name: _____ Signature: _____ Date: _____ Parent or
Guardian: _____ Signature: _____ Date: _____