PATIENT INFORMATION

First Name: _____ MI:_____ Last Name:_____

Street:_____Apt:_____

City:_____State:_____Zip:_____

Social Security #:_____Marital Status: S M W D Spouse:_____

DOB:_____ Home Phone:_____ Work Phone_____

Cell Phone:_____ E-mail:_____

Occupation:_____ Employer:_____

Employer Address:_____

Emergency Contact_____Phone #_____

INSURANCE INFORMATION

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is the policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name:_____MI:_____Last Name:_____

Policy Holder's DOB:_____Policy Holder's SS#:_____

Policy Holder's Employer:_____

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:
First Name:_____MI:_____Last Name:_____

Policy Holder's DOB:_____Policy Holder's SS#:_____

Policy Holder's Employer:_____

ASSIGNMENT & RELEASE

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt. However, I clearly 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 if I suspend or terminate my care and treatment, any fees or outstanding balances for services rendered will be immediately due and payable.

Patient, Parent, or Guardian Signature:_____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/ her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or an clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient, Parent or Guardian Signature:_____

1. Reason for visit (where do you hurt?)_____
2. When did symptoms appear?_____What caused the pain?_____
3. Is the condition getting progressively worse? yes no unknown
4. Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)_____
5. Type of pain- check all that apply: Sharp Dull Throbbing Numbness Aching
   Shooting Burning Tingling Cramping Stiffness Swelling
6. How often do you have this pain? _____
7. Is the pain constant, or does it come and go?_____
8. Does the pain interfere with- check all that apply: Work Sleep Daily Routine Recreation
9. Please indicate which activities that are painful to perform- check all that apply:
   Sitting Standing Walking Bending Lying Down

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1. Exercise: check the box that applies to you: None Moderate Daily Heavy
2. Work Activity: check the box that applies to you: Sitting Standing Light Labor Heavy Labor
3. Habits: Smoking Packs/Day_____
   Alcohol Drinks/Week_____
   Coffee/Caffeine Drinks/Cups/Day_____
   High Stress Level Reason_____
4. Are you pregnant? Yes No If so, due date: _____
5. Medications/Vitamins/Herbs/Minerals you are currently taking: _____
   _____
6. Please list any allergies you may have:_____
7. Please list any:

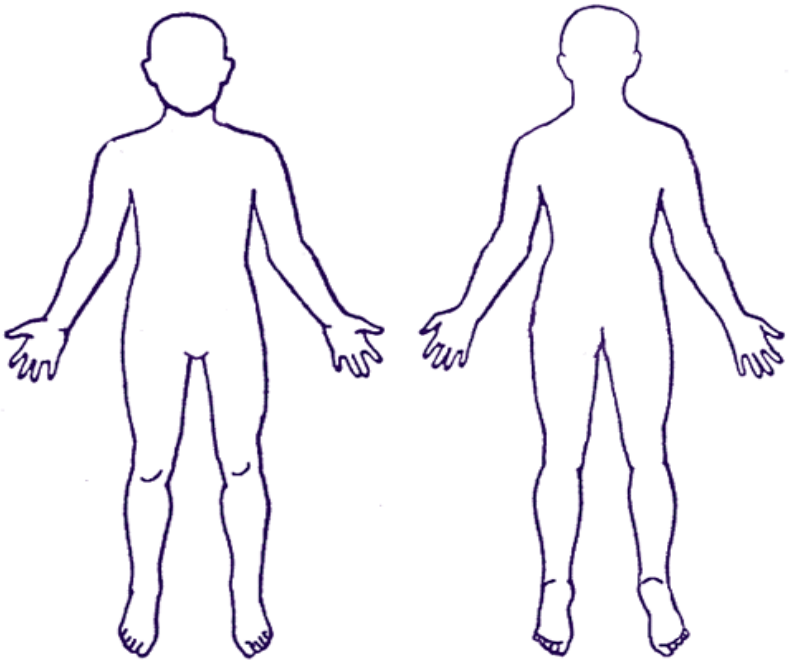
Falls:_____
_____Date:_____

Head Injuries:_____
_____Date:_____

Broken bones/Fractures/Dislocations:_____
_____Date:_____

Surgeries:_____
_____Date:_____

1. What other treatment have you already received for your condition?
   Medications Surgery Physical Therapy Chiropractic None
2. Name of other doctor(s) who have treated your condition: _____
_____
3. Place an X where you are having pain:



FRONT BACK

4. Circle Y (Yes) or N (No) if you have ever or currently are suffering from the following:

Y N....AIDS/HIV	Y N....Osteoporosis	Y N....Hernia
Y N....Alcoholism	Y N....Pacemaker	Y N....Herniated Disk
Y N....Allergy Shot	Y N....Parkinson's Disease	Y N....Herpes
Y N....Anemia	Y N....Pinched Nerve	Y N....High Cholesterol
Y N....Anorexia	Y N....Pneumonia	Y N....Kidney Disease
Y N....Appendicitis	Y N....Polio	Y N....Liver Disease
Y N....Arthritis	Y N....Prostrate Problems	Y N....Measles
Y N....Blood Disorders	Y N....Prosthesis	Y N....Migraine Headaches
Y N....Breast Lump	Y N....Psychiatric Care	Y N....Scarlet Fever
Y N....Bronchitis	Y N....Rheumatoid Arthritis	Y N....Stroke
Y N....Bulimia	Y N....Rheumatic Fever	Y N....Suicide Attempt
Y N....Cancer	Y N....Emphysema	Y N....Thyroid Problems
Y N....Cataracts	Y N....Epilepsy	Y N....Tonsillitis
Y N....Chemical Dependency	Y N....Fractures	Y N....Tuberculosis
Y N....Chicken Pox	Y N....Glaucoma	Y N....Tumors/Growths
Y N....Diabetes	Y N....Goiter	Y N....Typhoid Fever
Y N....Miscarriage	Y N....Gonorrhea	Y N....Ulcers
Y N....Mononucleosis	Y N....Gout	Y N....Vaginal Infections
Y N....Multiple Sclerosis	Y N....Heart Disease	Y N....Venereal Diseases
Y N....Mumps	Y N....Hepatitis	Y N....Whooping Cough