

(PLEASE PRINT CLEARLY)

What brought you to our clinic today?.....
Referred by: Dr Friend/Family..... Attorney
 Phone book Sign Newspaper..... Other

PATIENT DATA

Last Name First Name..... Middle
Preferred Name Gender M F DOB Age SSN
Address..... City..... State Zip.....
Home phone Work phone..... Cell phone.....
Preferred phone number..... Email..... Occupation
Marital Status Employed by.....
Spouse name..... Cell phone..... SSN
DOB: Occupation..... Employed by

EMERGENCY Name and phone number of nearest relative or friend not living with you.

Last Name First Name
Home Phone Cell Phone Work Phone
Relationship to Patient

PAYMENT METHOD For all services that are not paid by a third party Cash Check Credit / Debit Card

Is your visit as the result of an accident, other than motor vehicle or workers compensation? Yes No

If yes, and your personal injury case is still open, please complete Page 4. If your accident was motor vehicle or workers compensation, please see the receptionist to complete the appropriate form.

PRIMARY INSURANCE

Person responsible for account (if not yourself) Phone
Relationship to patient..... Birth Date Social Security #
Address (if different from patient)
Person responsible employed by Occupation
Business Address Phone
Insurance Company.....
Member/Subscriber # Group #

SECONDARY INSURANCE (if any)

Insurance Company.....
Member/Subscriber ID # Group #

PATIENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Jefferson Chiropractic Center, Inc 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 Jefferson Chiropractic Center, Inc will be credited to my account upon receipt. I permit Jefferson Chiropractic Center, Inc to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment even if my insurance company deems treatment not medically necessary. I also understand that if I suspend my care and treatment, any fees for professional services rendered me will be immediately due and payable. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees.

PATIENT/GUARDIAN SIGNATURE Date.....

GUARDIAN'S NAME (Please print).....

(PLEASE PRINT CLEARLY)

MEDICAL AND HEALTH HISTORY

Patient Name..... Date of Birth.....

MAIN PROBLEM

What symptoms cause you to come to this office? (e.g. numbness, pain, tingling, reduced range of motion, etc.) For symptoms other than pain, please explain here

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.....

If pain, what caused this pain?

When did this pain start (date) How long does this pain last?.....

How bad is the pain? (Circle one; 1 = mild pain; 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Cramping Aching Dull Sharp Shooting Bright Diffuse
Lightening like Throbbing Nagging Burning Stinging Pressure like

How often does the pain occur? (Circle one): Occasionally Frequently Constantly

Does this pain travel to any other area?

What makes the pain better?

What makes the pain worse?.....

What else have you done to treat this pain?

OTHER PROBLEMS

For symptoms other than pain, (e.g. numbness, reduced range of motion, etc.) please explain here

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What other pain do you have?.....

What caused this pain?.....

When did this pain start (date) How long does this pain last?.....

How bad is the pain? (Circle one – 1 = mild pain; 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Cramping Aching Dull Sharp Shooting Bright Diffuse
Lightening like Throbbing Nagging Burning Deep Stinging Pressure like

How often does the pain occur? (Circle one): Occasionally Frequently Constantly

Does this pain travel to any other area?

What makes the pain better?

What makes the pain worse?.....

What else have you done to treat this pain?

(PLEASE PRINT CLEARLY)

OTHER HISTORY

- Allergies? (e.g. latex) Yes No If yes, to what?
- Do you smoke? Yes No If yes, how many per day?.....
- Do you drink? Yes No If yes, what and how much?
- Do you exercise regularly? Yes No If yes, how often?
- Are you pregnant? Yes No Date of last physical exam.....
- Are you employed? Yes No Where?.....

OTHER MEDICAL INFORMATION

WHICH OF THE FOLLOWING ARE YOU EXPERIENCING? (Check all that apply)

- Anxiety Tremors Chest Pain Loss of Taste
- Tension Dizziness Irritability Loss of Smell
- Fainting Diarrhea Palpitation Double vision
- Insomnia Neck pain Depression Neck stiffness
- Loss of memory Headache Constipation Pins & needles in arms/legs
- Feet/hands cold Digestive disorders Eyes sensitive to light Nausea/vomiting
- Shortness of breath Ears buzzing/ringing Numbness in fingers/arms/legs Equilibrium problems
- Mid back pain/stiffness Low back pain/stiffness Upper back pain/stiffness Difficulty in prolonged car Riding

HAVE YOU HAD OR DO YOU HAVE? (Check all that apply)

- Diabetes Stroke Dizziness Tuberculosis High blood pressure Rheumatic fever
- Asthma Neuritis Numbness Heart problems Venereal disease Kidney Disease/stones
- Hepatitis Anemia Backaches Bleeding Tendency Sinus trouble Multiple Sclerosis
- Epilepsy Polio HIV/AIDS Convulsions Arthritis German measles
- Nervousness Concussion Scarlet Fever Rheumatism Muscular Dystrophy
- Cancer (where)..... Other

How is your overall health?

ILLNESSES/SURGERIES/HOSPITALIZATIONS/INJURIES/	MEDICATIONS	PURPOSE
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Patient/Guardian Signature **Date**

(PLEASE PRINT CLEARLY)

IF YOUR VISIT IS DUE TO A TRAFFIC ACCIDENT FOR WHICH THE CLAIM IS STILL OPEN, PLEASE COMPLETE THE PERSONAL INJURY QUESTIONNAIRE FORM

IF YOUR VISIT IS DUE TO A WORKER'S COMPENSATION INJURY FOR WHICH THE CLAIM IS STILL OPEN, PLEASE COMPLETE THE WORKERS COMPENSATION INJURY QUESTIONNAIRE FORM

IF YOUR VISIT IS DUE TO ANOTHER TYPE OF PERSONAL INJURY ACCIDENT, PLEASE DESCRIBE BELOW ALL EVENTS ASSOCIATED WITH THAT INJURY

Patient NameDOB
Date of accident:Time of accident: Place of Accident
Which State?Number of days, if any, missed from work due to accident.....

OTHER PERSONAL INJURY ACCIDENT (e.g. NOT motor vehicle or work related accident)

Address of Accident
Was the accident reported? Yes No
If yes, to whom?Date reported?.....
What is that person's position?Telephone Number.....
Who is their insurer?
Address of insurer
Has a claim been filed? Yes No If yes, what is the claim number?
Name of your adjuster
Adjuster's telephone number
Have you appointed an Attorney? Yes No If yes, name & address
.....Telephone number
Please describe how the accident happened

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Patient/Guardian Signature Date.....