(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, <u>and your personal injury case is still open</u>, 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 (***If you have more than one problem, complete "OTHER PROBLEMS" below***)

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

....

....

....

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 (***Do not include your main problem***)

What other areas, if any, do you have symptoms? (e.g. numbness, reduced range of motion, etc.) Please explain here: ....

....

....

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
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....

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 Name ....DOB ....

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** ....