Confidential Patient Information

Name _____ Birth Date _____ Age ____ Sex M F

Address_____ Apt.# _____

City_____ State _____ Zip Code (+4 if known)_____

Cell Phone( )_____Home Phone ( )_____

Best # to call: Cell Home Your Social Security Number _____ Marital Status S M D W

Occupation _____ Employer _____

Email address _____
(We only send informational emails (i.e. office news). We will never share your email address!)

Emergency Contact Information

Emergency contact person (other than your spouse) _____

That person's telephone number at home ( ) _____ Work ( ) _____

Guarantor Information

Guarantor's Name _____

Birth Date_____ Social Security Number_____

Guarantor's Occupation _____ Employer_____

PLEASE READ CAREFULLY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Integrated Chiropractic Rehab will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Integrated Chiropractic Rehab will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that all past, present, and future bills incurred at Integrated Chiropractic Rehab are my responsibility for payment. In the event that my bill must be turned over to an attorney for collection, I understand that I am liable for the balance due plus interest at the current rate, reasonable attorney fees, and court costs. I authorize the release of any medical information necessary to process my claims.

PAYMENT IS DUE AT THE TIME OF THE VISIT

Patient's Signature _____ Date_____

Guarantor's Signature_____ Date_____

Patient Name _____ Date _____ File _____

PAST MEDICAL HISTORY

Please list any current or past:

Surgeries (date(s), if possible) _____

_____

Broken Bones _____

Accidents or Serious Injuries _____

Allergies/Other Serious Illness_____

History of smoking (circle one) NO YES _____ packs per day for _____ years. Year you quit _____

FAMILY HISTORY

Please list immediate blood relatives who have had any of the following:

Musculoskeletal Disease _____ Heart Disease _____

Cancer _____ Lung Disease_____

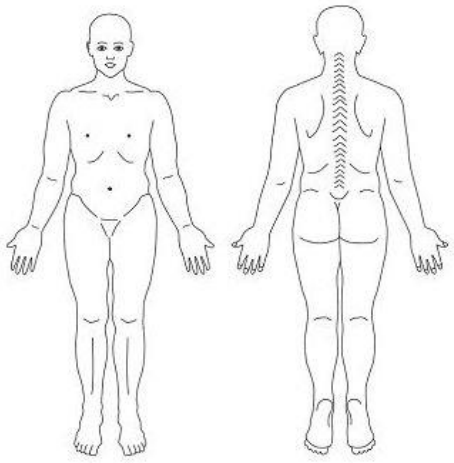
Nervous Disorder _____ Metabolic Disorder (diabetes, thyroid) _____

MEDICATIONS [] Check here if you have provided a list

Please list ALL current medications and vitamin supplements

1. _____2. _____ 3. _____

4. _____5. _____6._____



Please circle your current pain level on a scale of 0 (no pain) to 10 (worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

Describe the quality of the pain/symptom (circle as many as apply)

Sharp Dull Achey Tingling Burning Throbbing Other _____

How frequently do you experience the pain? (circle one)

Constantly	Frequently	Intermittently	Occasionally
76-100% of the day	50-75% of the day	26-50% of the day	0-25% of the day

What makes the pain better? Rest Medication Walking Stretching Lying Down Exercise Other _____

What makes the pain worse? Bending Twisting Lifting Coughing Sneezing Sitting Standing Lying Down Temperature Changes Other _____

Please mark the area(s) below where you are currently experiencing pain/symptoms:

When did this pain begin? _____ Have you had the same pain before? Yes No

What caused the pain? _____

Is this condition related to (circle any that applies): Job accident Auto Collision Home Injury Unknown

Whom have you seen for this condition? _____

What treatment or evaluation was performed? _____

Are you still under care? Yes No If "Yes," when was your last visit? _____

Who is your family doctor? _____Last Checkup _____

Have you had prior Chiropractic or Acupuncture? Yes No If so, when was your last treatment? _____

FOR OFFICE USE ONLY Height ____ Feet _____ Inches Weight _____ lbs. Temperature _____ F

Pulse _____ bpm Seated LABP _____/_____ Seated RABP _____/_____ Hautant's POS NEG @ 30 sec