

PATIENT INTRODUCTION FORM

Patient Name:	Today's Date:
Address:	Home Telephone:
City/State/Zip:	Work Telephone:
Date of Birth: Age:	E-Mail address:
Height: Weight:	Employer's Name:
Social Security No:	Employer's Address:
Drivers License No:	Job Title:
How did you hear about us?	Marital Status (Circle): Single, Married, Divorced, Widowed

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

IS THIS VISIT RELATED TO A:

- | | | |
|--|---|--|
| <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Motorcycle-Bicycle Injury | <input type="checkbox"/> Home Injury |
| <input type="checkbox"/> Sports or Recreational Injury | <input type="checkbox"/> Non-Injury Symptoms | <input type="checkbox"/> Check-up Only |
| <input type="checkbox"/> Car Crash Injury | <input type="checkbox"/> School/Employment Physical | <input type="checkbox"/> Other (Describe): |

INSURANCE INFORMATION

Does your insurance cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card). If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name. If unknown, be certain to let the front desk staff know.	Carrier Name: Address: Telephone: Claim Number: Claim Adjusters Name:
Are you the insured person or dependent (wife/husband/child)?	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, and the name of the insured employers business.	Name of Insured Person: Social Security Number: Insured Date of Birth: Name of Insured Company:
What is your co-payment amount for each visit?	Amount: \$
What percentage does your insurance pay?	Percentage (%):
What is your insurance deductible amount each year?	Amount: \$
Have you met your deductible this year?	<input type="checkbox"/> Yes, <input type="checkbox"/> No
Does your insurance policy limit each office payment amount?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Limit is: \$
Does your insurance limit the number of office visits per year?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Number:
Does your insurance limit the amount paid per year?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Limit is: \$

Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent): _____ Date: _____

PAST AND PRESENT GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or currently have:

YES	GENERAL QUESTIONS	YEAR
<input type="checkbox"/>	I bruise easily currently	N/A
<input type="checkbox"/>	I heal slowly currently	N/A
<input type="checkbox"/>	Smoke cigarettes currently or in the past	N/A
<input type="checkbox"/>	Diabetic	
<input type="checkbox"/>	Heart Attack history (recent and old)	
<input type="checkbox"/>	Epilepsy-Seizure history	
<input type="checkbox"/>	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	
<input type="checkbox"/>	Cancer history or treatment of any type	
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, disc degeneration, or a herniated disc	
<input type="checkbox"/>	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	
<input type="checkbox"/>	Rheumatoid arthritis	
<input type="checkbox"/>	Thyroid disorders	
<input type="checkbox"/>	Coma from head injury or other problem	
<input type="checkbox"/>	Told you have High Blood Pressure	
<input type="checkbox"/>	Told you have osteoporosis of your spine	
<input type="checkbox"/>	Told you have osteoarthritis of your spine or hip joints	
<input type="checkbox"/>	Women only: Check this box if you currently have any type of breast implants	N/A
<input type="checkbox"/>	Women only: Check this box if there ANY chance that you are currently pregnant	N/A

FAMILY HISTORY OF:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cardiovascular Problems/Stroke
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FRACTURES/BROKEN BONES

I have never had any broken bones. If you have broken any bones, indicate where and when:

Region	Year	Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Pelvis bone		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Leg or foot bone		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bone				<input type="checkbox"/> Other	

PREVIOUS SURGERIES

I have never had any surgical procedure. If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck or back)		<input type="checkbox"/> Rib/Collar bone		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Hernia		<input type="checkbox"/> Head/Brain	
<input type="checkbox"/> Heart		<input type="checkbox"/> Shoulder/Arm/Leg		<input type="checkbox"/> Other	

☞ DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Please circle any word or words below that best describe how your symptoms currently feel to you.

Pain	Pinching	Spreading	Pulling	Boring	Unbearable	Pressing	Falls asleep
Ache	Pricking	Shooting	Irritating	Burning-Hot	Soreness	Deep pain	Crawling
Cutting	Tingling	Stabbing	Tender	Drill like	Pins and Needles	Superficial pain	Miserable
Tearing	Gnawing	Dull	Stiff or tight	Heavy	Radiating	Stinging	Falls asleep
Crushing	Nagging	Bony	Exhausting	Numbness	Weakness	Throbbing	Sharp

ARE YOU TAKING ANY MEDICATIONS?

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Stroke prevention meds	<input type="checkbox"/> Anacin	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Anti-inflammatory	<input type="checkbox"/> Birth control medications	<input type="checkbox"/> Bufferin	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Heart medications	<input type="checkbox"/> Narcotics for Pain	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Other

HAS YOUR PAIN BEEN ASSOCIATED WITH:

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

SYMPTOM INTENSITY AND FREQUENCY FORM

PATIENT: _____ DATE: _____

For **SECTION 1**, describe on a scale of 1-10 how intense your pain (includes mild to severe amount of aching, soreness, hurting, or pain), numbness, and/or tingling levels are currently. A zero (0) indicates that no symptoms exist. A **1-3 level** is a mild level and indicates that your pain is an annoyance primarily. A **4-7 level** is moderate pain that restricts or limits your ability to perform some activities to some degree. A **8-10 level** is severe and means that the pain intensity is to point where you are unable to perform most activities. A **10 level** pain is equal to the most severe pain you have ever had and means that you are unable to do anything. For **SECTION 2**, describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion. For **SECTION 3** indicate the type and location of your sensations.

SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	Mild			Moderate				Severe		
		Discomfort/Ache/Stiff			Hurts/Sore/Bearable Sensation				Sharp/Intense Pain		
My Pain Level Today	0	1	2	3	4	5	6	7	8	9	10

SECTION 2a. CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional		Intermittent		Frequent				Constant	
	Pain % of time	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%

SECTION 2b. CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

A. How frequently do you have headaches currently?

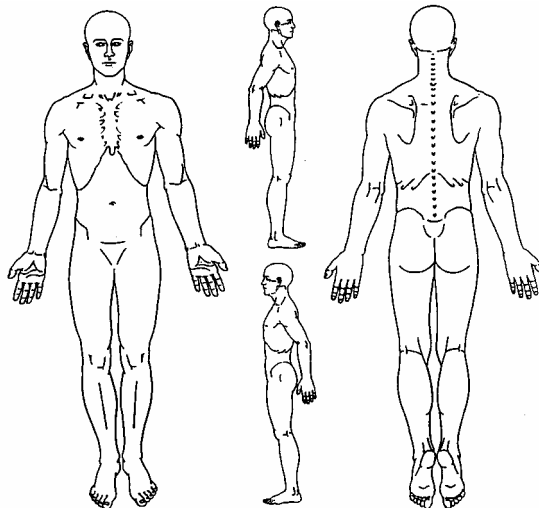
<input type="checkbox"/> No headaches	<input type="checkbox"/> once a week	<input type="checkbox"/> 4 times a week
<input type="checkbox"/> once a month	<input type="checkbox"/> twice a week	<input type="checkbox"/> 5 times a week
<input type="checkbox"/> twice a month	<input type="checkbox"/> 3 times a week	<input type="checkbox"/> Almost daily

B. How many hours does your typical headache last? _____ Hours?

SECTION 3. CURRENT PAIN LOCATIONS

Use the letters below to indicate the type and location of your sensations right now

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
 P=PINS & NEEDLES **S**=STABBING **O**=OTHER



Have you had any new injuries No, Yes If yes, describe: _____