CONFIDENTIAL PATIENT INFORMATION

Dear Patient: Please complete this questionaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Work Telephone _____ # Children _____ Spouse's Name _____

Occupation _____

Name and address of employer _____

HEALTH INFORMATION

Have you had previous chiropractic care? ☐ Yes ☐ No

Main Complaint _____

_____

Other Complaints _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Does this condition effect your work? Yes ☐ No ☐

Does this condition effect your family or social life? Yes ☐ No ☐

What aggravates this condition? _____

_____

Other Doctors seen for this condition: _____

_____

Are you taking any medication? _____

_____

What helps your symptoms? _____

Have you had any surgery, falls or accidents? Yes ☐ No ☐

When _____ Please describe _____

_____

Date of last physical examination _____

Women: Are you pregnant, or is there any possibility you are pregnant? ☐ Yes ☐ No

INSURANCE INFORMATION

Is this condition due to:

A work related injury Yes ☐ No ☐ An automobile accident Yes ☐ No ☐

If you answer yes to either of the above questions, please complete other side of form.

Are you covered by Medicare? ☐ Yes ☐ No Medicare # _____

Do you have Major Medical Health Insurance? Yes ☐ No ☐ Insured's Name _____ SS # _____

Insurance Company _____

Address _____

Name of Employer _____

Address _____

Group # _____ Employee # _____

I **understand and agree** that health and accident insurance policies are an arrangement between an insurance carrier and myself. **Furthermore, I understand** that Chiro Care Associates 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 the Chiro Care Associates 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 if I suspend or terminate my care and treatment, any fees for professional services rendered me will be **immediately** due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

Information Taken By: _____ Date: _____

Complete for Both JOB INJURY or ACCIDENT

Check symptoms you have noticed since accident:

☐ Headache	☐ Dizziness	☐ Light Bother Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pains	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ _____

Symptoms other than above _____

List the extent of the injuries as you know them _____

_____

_____

Hospitalized? ☐ Yes ☐ No Name of Hospital _____ X-rays taken ☐ Yes ☐ No_____

Other Doctors seen _____

Are you working now? _____

Time lost from work _____ to _____ (dates)

_____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

Name _____

Address _____ Telephone _____

CONTINUE FOR EITHER JOB or ACCIDENT INFORMATION:

Complete only for:

JOB INJURY INFORMATION:

Date _____ Time _____ Location_____

Description of accident _____

_____

_____

Workman's Compensation Case # _____

Insurance Company _____ Address _____

Insurance Company Case # _____

Employer's Name _____ Address _____

Complete only for:

ACCIDENT INFORMATION:

Date _____ Time _____ Location _____

How did accident occur? ☐ Auto Collision ☐ Other _____

If not an auto collision, please describe the circumstances: _____

_____

_____

If auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was Parked

Did your car strike the other(s) involved? ☐ Yes ☐ No

Or did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

To the driver of the other car? ☐ Yes ☐ No

To the driver of your car? ☐ Yes ☐ No

My Company _____ Address _____

Registered Owner _____ Policy No. _____ Case No. _____

Other Driver's Insurance Company _____