PATIENT (LEGAL) NAME:_____ SEX:_____ BIRTHDATE:_____

PREVIOUS/MAIDEN NAME(s): _____ SSN:_____

PHYSICAL ADDRESS:_____
City State Zip

MAILING ADDRESS:_____
City State Zip

PHONE: HOME/CELL:_____ EMAIL: _____

EMPLOYER:_____ PHONE:_____

SPOUSE NAME:_____ SPOUSE DOB:_____ PHONE:_____

EMERGENCY CONTACT (OUTSIDE OF HOME):_____ PHONE:_____

HOW DID YOU HEAR ABOUT US? _____

AUTO INSURANCE INFORMATION

POLICYHOLDER NAME:_____ INSURANCE COMPANY:_____

ADDRESS:_____ PHONE:_____

CLAIMS ADJUSTER:_____ PHONE:_____

CLAIM NUMBER:_____ STATE OF ACCIDENT:_____ ACCIDENT DATE:_____

ATTORNEY:_____ PHONE:_____

SHOULD THE AUTO INSURANCE DENY LIABILITY FOR THE CHARGES, YOU ARE FINANCIALLY RESPONSIBLE. WE CAN BILL YOUR PRIVATE INSURANCE

(**Please note**: *Please provide your private insurance information and/or a copy of your Insurance Card.)*

POLICYHOLDER NAME:_____ DOB:_____ RELATION:_____

INSURANCE COMPANY:_____ ID/CLAIM #:_____ GROUP #:_____

IF UNDER 18 OR A COVERED DEPENDENT

MOTHER'S INFORMATION:

NAME: _____ DOB:_____ PHONE:_____

ADDRESS:_____ EMPLOYER:_____ WORK PHONE:_____

FATHER'S INFORMATION:

NAME: _____ DOB:_____ PHONE:_____

ADDRESS:_____ EMPLOYER:_____ WORK PHONE:_____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARANTOR IF PATIENT IS A MINOR) DATE

NAME: _____ DATE: _____

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU CURRENTLY ENGAGING IN ANY FORM OF EXERCISE? _____

IF YES, LIST ACTIVITY, FREQUENCY AND INTENSITY: _____

2. HOW ACTIVE IS YOUR LIFESTYLE? _____ SEDENTARY ____ MODERATE PHYSICAL ACTIVITY _____ HEAVY PHYSICAL ACTIVITY

3. WHAT IS YOUR JOB TITLE IF CURRENTLY WORKING?_____
DESCRIBE THE TYPES OF ACTIVITIES INVOLVED IN YOUR JOB (HEAVY LIFTING, STAIR CLIMBING, WALKING, SITTING AT DESK, ETC):

_____

_____

4. PLEASE INDICATE YOUR EXPECTATIONS AND GOALS FOR YOUR TREATMENT:_____

_____

B. **PLEASE FILL OUT YOUR PAIN LEVELS AND MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.**

PAIN / DISCOMFORT/DIZZINESS DESCRIPTION

SYMPTON FREQUENCY:

_____ CONSTANT
_____ COMES AND GOES AT REGULAR TIMES
_____ HAPPENS ONCE IN A WHILE

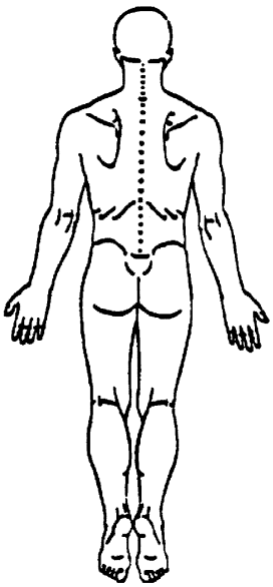
RELATIONSHIP OF SYMPTOMS TO SLEEP:

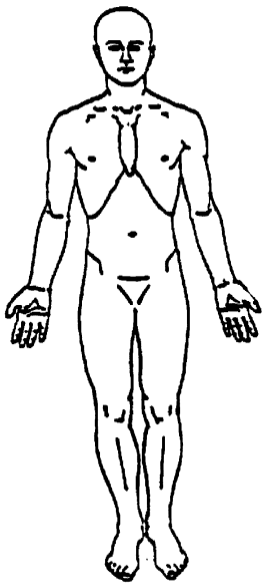
_____ WAKES FROM SLEEP
_____ PREVENTS SLEEP
_____ BETTER AFTER SLEEP

SYMPTOM SCALE- 0 BEING NONE AT ALL 10 BEING AS BAD AS IT CAN BE

AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness





PATIENT SIGNATURE:
_____ DATE:_____

NAME:_____ DATE:_____

MEDICAL HISTORY:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____ ALZHEIMER'S	_____ HIGH BLOOD PRESSURE	_____ OSTEOARTHRITIS
_____ CARDIOVASCULAR DISEASE	_____ HISTORY OF CANCER	_____ PARKINSON'S
_____ CURRENT INFECTION	_____ HUNTINGTON'S	_____ PREGNANT/POSSIBLY PREGNANT
_____ CVA/STROKE	_____ LUPUS	_____ RHEUMATOID ARTHRITIS
_____ DIABETES TYPE 1/TYPE 2 (CIRCLE)	_____ MUSCULAR DYSTROPHY	_____ TRAUMATIC BRAIN INJURY
_____ FIBROMYALGIA	_____ HIV, HEPATITIS B, HEPATITIS C	

_____ PREVIOUS FRACTURED BONES (IF SO WHICH ONES):_____

SURGICAL HISTORY:_____

OTHER: _____

PLEASE LIST BELOW YOUR CURRENT PRESCRIPTION(S), OVER-THE-COUNTER, HERBAL, VITAMIN/ MINERALS / DIETARY (NUTRITIONAL SUPPLEMENTS) MEDICATIONS. IF YOU HAVE A CURRENT LIST OF YOUR MEDICATIONS WITH ALL OF THE BELOW INFORMATION, PLEASE PROVIDE IT TO THE FRONT OFFICE AND THEY CAN MAKE A COPY.

PRESCRIPTION MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

OVER-THE-COUNTER / HERBAL/ VITAMIN /MINERAL / DIETARY (NUTRITIONAL SUPPLEMENT):

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

For Future Appointments Only

I _____, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_____ DATE:_____

I _____, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_____ DATE:_____