



Name: _____ Age: _____ Date: _____ Case Number: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone:(H) _____ (C) _____ Fax: _____ E-mail: _____
 Date of Birth: _____ Sex: M F Marital Status: S M D W # of Children: _____
 Occupation: _____ Employer: _____ Telephone (Work): _____ Ext. _____
 Spouse's Name: _____ Spouse's Occupation: _____
 Spouse's Employer: _____ Spouse's Telephone (Work): _____
 Past Chiropractic Care: Yes No When? _____ Doctor's Name: _____
 Results: _____ Referred by: _____
 Telephone: _____

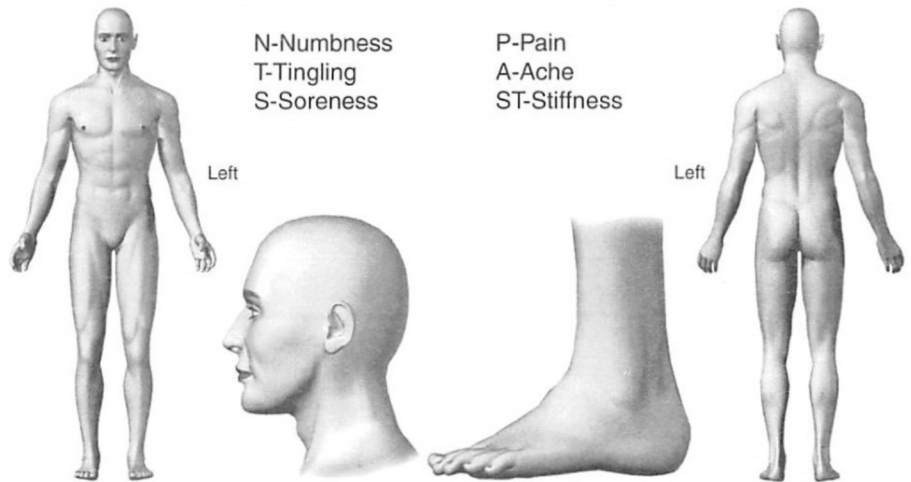
Emergency Contact: _____ Relationship _____ Contact Number _____

Are your present problems due to an injury? No Yes On the Job Auto Accident Personal Injury Other: _____
 Has the accident been reported? No Yes To Employer Auto Carrier Other: _____
 Are you now or have you ever been disabled? (Service or Work)? No Yes When? _____ Why? _____
 Have you retained an attorney? No Yes Name & Address: _____

Pain Symptoms: 1. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 (in order of 2. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 severity) 3. _____ Began-(Mo/Yr): _____ Previous Episodes: _____

Please mark the intensity of your pain today.
 0 - NO PAIN
 10 - INTENSE PAIN
 Example _____ Neck _____
 0 1 2 3 4 5 6 7 8 9 10
 1. _____
 0 1 2 3 4 5 6 7 8 9 10
 2. _____
 0 1 2 3 4 5 6 7 8 9 10
 3. _____
 0 1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below.



DOCTORS USE ONLY

HABITS		EXERCISE		FAMILY HISTORY					
<input type="checkbox"/> Smoking	Packs/Day: _____	<input type="checkbox"/> None		Diabetes	Heart	Kidney	Cancer	Other	
<input type="checkbox"/> Drinking	Alcohol: _____	<input type="checkbox"/> Light Activity		Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Caffeine	Cups/Day: _____	<input type="checkbox"/> Moderate Activity		Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Active		Brother, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Very Active		Sister, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Elite Athlete							

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

<input type="checkbox"/> 541 Appendicitis	<input type="checkbox"/> 280 Anemia	<input type="checkbox"/> 429.9 Heart Disease	<input type="checkbox"/> 716 Arthritis
<input type="checkbox"/> 480 Pneumonia	<input type="checkbox"/> 055 Measles	<input type="checkbox"/> 240 Goiter	<input type="checkbox"/> 345 Epilepsy
<input type="checkbox"/> 390 Rheumatic Fever	<input type="checkbox"/> 072 Mumps	<input type="checkbox"/> 487 Influenza	<input type="checkbox"/> 319 Mental Disorder
<input type="checkbox"/> 045 Polio	<input type="checkbox"/> 052 Chicken Pox	<input type="checkbox"/> 511 Pleurisy	<input type="checkbox"/> 724.2 Lumbago
<input type="checkbox"/> 011 Tuberculosis	<input type="checkbox"/> 250 Diabetes	<input type="checkbox"/> 303.9 Alcoholism	<input type="checkbox"/> 690 Eczema
<input type="checkbox"/> 033 Whooping Cough	<input type="checkbox"/> 239 Cancer	<input type="checkbox"/> 099 Venereal Disease	<input type="checkbox"/> 042 HIV Positive
<input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> 346.9 Migraine Headaches	<input type="checkbox"/> 054.9 Herpes	<input type="checkbox"/> 340 Multiple Sclerosis

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. Never Previously Presently.

<table border="0"> <tr> <td style="text-align: center;">Never Previously Presently</td> <td>GENERAL SYMPTOMS</td> <td style="text-align: center;">Never Previously Presently</td> <td>GASTRO-INTESTINAL</td> <td style="text-align: center;">Never Previously Presently</td> <td>EYE/EAR/NOISE/THROAT</td> <td style="text-align: center;">Never Previously Presently</td> <td>RESPIRATORY</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>995.3 Allergy (What)_____</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>787.3 Belching/Gas/Bloating</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>493.9 Asthma</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>786.50 Chest Pain</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>490 Bronchitis</td> <td><input type="checkbox"/> 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<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	780.79 Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	455 Hemorrhoids (piles)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	240.9 Enlarged Thyroid																																																																																																																																																																																																																										
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	780.79 Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	782.4 Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	460 Frequent Colds																																																																																																																																																																																																																										
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	780.6 Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	794.8 Liver Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	477 Hay Fever																																																																																																																																																																																																																										
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	784.0 Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	787.02 Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	784.49 Hoarseness			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	788.36 Bed Wetting																																																																																																																																																																																																																						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	780.52 Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	536.9 Stomach Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	478.1 Nasal Obstruction			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	599.7 Blood in Urine																																																																																																																																																																																																																						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	783 Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	783.0 Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	784.7 Nosebleeds			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	788.4 Frequent Urination																																																																																																																																																																																																																						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	799.2 Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	536.8 Poor Digestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	379.91 Pain in Eyes			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	788.3 Lack of Bladder Control																																																																																																																																																																																																																						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	729.2 Neuralgia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	787.03 Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	368.9 Poor Vision			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	590.9 Kidney Infection																																																																																																																																																																																																																						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	780.8 Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	578.0 Vomiting Blood	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	461.9 Sinusitis			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	788.1 Painful Urination																																																																																																																																																																																																																						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	786.07 Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	783.5 Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	462 Sore Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	601.9 Prostate Trouble																																																																																																																																																																																																																								
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	311 Depression	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	536.8 Indigestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	463 Tonsillitis																																																																																																																																																																																																																										
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	569.3 Rectal Bleeding	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	786.2 Persistent Cough																																																																																																																																																																																																																										
				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	787.2 Difficulty Swallowing																																																																																																																																																																																																																										
				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	523.8 Bleeding Gums																																																																																																																																																																																																																										
MUSCLES/JOINTS/BONES	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR WOMEN ONLY																																																																																																																																																																																																																												
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724.5 Backache	401.9 High Blood Pressure	680.9 Boils	625.3 Cramps or Backaches																																																																																																																																																																																																																												
719.7 Foot Trouble	458.9 Low Blood Pressure	924.9 Bruising Easily	626.2 Excessive Flow																																																																																																																																																																																																																												
550 Hernia	786.51 Pain Over Heart	701.1 Dryness	627.2 Hot Flashes																																																																																																																																																																																																																												
719.1 Pain Between Shoulders	785.9 Poor Circulation	691.8 Eczema	626.4 Irregular Cycle																																																																																																																																																																																																																												
	438 Previous Heart Trouble	708.9 Hives or Allergy	634.9 Miscarriage																																																																																																																																																																																																																												
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																																																																																																																																																																												
724.6 Painful Tail Bone	785.0 Rapid Heart	698.9 Itching	625.3 Painful Periods																																																																																																																																																																																																																												
723.9 Stiff Neck	427.89 Slow Heart	782.0 Sensitive Skin	623.5 Vaginal Discharge																																																																																																																																																																																																																												
781.9 Spinal Curvature	436 Strokes	782.1 Skin Eruptions	611.79 Lump in Breast																																																																																																																																																																																																																												
719.0 Swollen Joints	719.7 Swelling Ankles		<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this time?																																																																																																																																																																																																																												
781.0 Tremors/Twitching	454 Varicose Veins		<input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a mammogram?																																																																																																																																																																																																																												
782 Arm Trouble			_____ Last Pap Smear Date																																																																																																																																																																																																																												
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OPERATIONS AND PROCEDURES

<table border="0"> <tr> <td style="text-align: center;">DATE</td> <td>Vaccinations</td> <td style="text-align: center;">DATE</td> <td>Tubes in Ears</td> <td style="text-align: center;">DATE</td> <td>Sinus</td> </tr> <tr> <td>_____</td> <td>Tonsillectomy</td> <td>_____</td> <td>Appendectomy</td> <td>_____</td> <td>Hernia</td> </tr> <tr> <td>_____</td> <td>Gall Bladder</td> <td>_____</td> <td>Female Organs</td> <td>_____</td> <td>Thyroid</td> </tr> <tr> <td>_____</td> <td>Back Operation</td> <td>_____</td> <td>Rectal Surgery</td> <td>_____</td> <td>Stomach</td> </tr> <tr> <td>_____</td> <td>Other: _____</td> <td>_____</td> <td>Other: _____</td> <td>_____</td> <td>Other: _____</td> </tr> </table>	DATE	Vaccinations	DATE	Tubes in Ears	DATE	Sinus	_____	Tonsillectomy	_____	Appendectomy	_____	Hernia	_____	Gall Bladder	_____	Female Organs	_____	Thyroid	_____	Back Operation	_____	Rectal Surgery	_____	Stomach	_____	Other: _____	_____	Other: _____	_____	Other: _____	<table border="0"> <tr> <td><input type="checkbox"/> I have never had any operations / surgeries</td> </tr> </table>	<input type="checkbox"/> I have never had any operations / surgeries
DATE	Vaccinations	DATE	Tubes in Ears	DATE	Sinus																											
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_____	Other: _____	_____	Other: _____	_____	Other: _____																											
<input type="checkbox"/> I have never had any operations / surgeries																																

List any accidents or falls and dates: Car: _____ Recreation: _____
 Sports: _____ School: _____ Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? Yes No Why? _____

Have you ever had any spinal taps or spinal injections? Yes No Were you ever knocked unconscious? Yes No

Have you ever had a lapse of memory? Yes No

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over-the-counter? Yes No What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X _____ Date: _____



Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520).

We reserve the right to change our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Patient's/Guardian's Signature: X_____ Date: _____