Have you been treated by a chiropractor before? No ☐ Yes ☐

Please list current medications: ____

____

Please list any known allergies: ____

Please list previous surgeries: ____

Please list significant injuries (sprain, strain, fracture dislocation, etc.) ______________________

____

How did you hear about our office? ____

General Information

Legal Name: ____

Address: ______________________ City: __________ State: ______ Zip: ______

Home Phone: ______________________ Work Phone: ______________________ ______

Date of Birth: ______________ Age:________ S.S.N.:______________________ ______

Occupation: ______________________ Employer: ______________________

Insurance Company Name: ____

Member Services Phone #: ______________________ I.D. # ______________________

Group/Plan #: ______________________

Name of Insured (if different from patient): ______________________ S.S.N. __________

Date of Birth: __________ Phone: __________ Employer: ______________________

Contacting Your Physician

As a courtesy, with your permission, we may submit a report of your present condition to your primary care physician or referring physician.

☐ Yes, you have my permission to submit a report of my present condition to my physician.

☐ No, you do not have my permission to submit a report of my present condition to my physician.

If yes, please provide the following:

Name of physician: ______________________

Address: ______________________ City, State, Zip Code: ______________________

Telephone Number: ______________ Fax Number: ______________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Active Spine and Joint Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________	______________________	______________
Responsible party signature	Relationship	Date

NAME: ______________________________	DATE: ____________________

Current Complaints

What is the reason for your visit today?____

____

____

When did this condition first appear? ____

Cause of condition: ____

Is the condition getting better, worse or staying the same? ______________________________

Have you had anything like this before? No ☐ Yes ☐ If Yes, how often? ____________________

Is the pain: Constant ☐ On and off ☐ If on and off, each episode lasts: ____________________

Does the pain radiate? No ☐ Yes ☐ If Yes, to which part of your body? ____________________

Does this condition interfere with: Work ☐ Sleep ☐ Daily routine ☐ Recreation ☐

What makes your condition feel better? ____

What makes your condition feel worse? ____

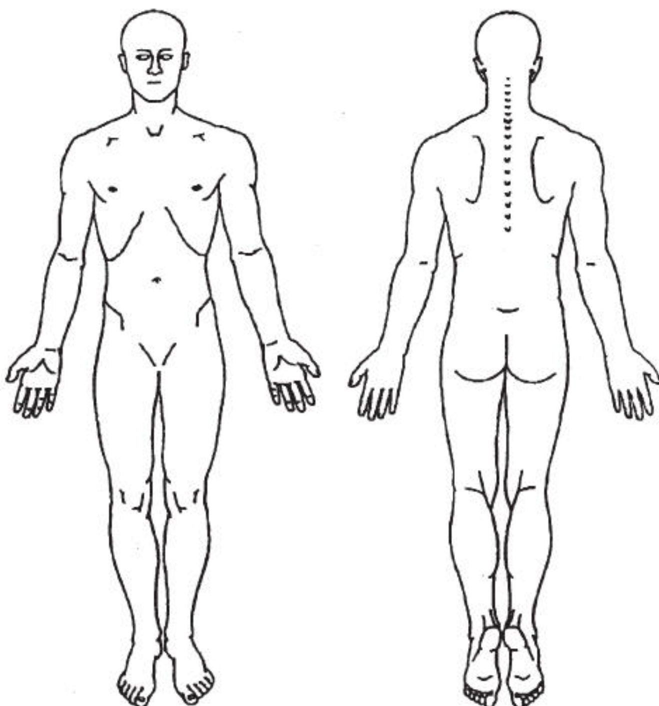
Please list activities that are painful or difficult to perform due to this condition: ________________

____

Describe previous treatment or self care: ____

____

Please mark the areas of injury or discomfort on the diagrams below



Please rate your pain on the scale below by circling the appropriate number

(0 = no pain, 10 = worst pain imaginable)

Pain Currently

0 1 2 3 4 5 6 7 8 9 10

Pain at its Worst

0 1 2 3 4 5 6 7 8 9 10

Pain Typically

0 1 2 3 4 5 6 7 8 9 10