

WELCOME!

01/11

Today's Date _____

Name _____ Date of Birth _____ Phone _____

What do you prefer to be called? _____ Age _____ SS# _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer Name _____

Work Phone # _____ Employer's Address _____

Marital Status: ()Single ()Married ()Divorced Spouse's Name _____

Who may we thank for referring you to our office? _____

Have you ever been treated by a Chiropractor? _____ If so, whom? _____

INSURANCE INFORMATION

Insured's Name _____ Relation _____ Date of Birth _____

Insured's SS# _____ Insured's Employer _____

Your Ins. Co. _____ Policy # _____

Ins Co. Address _____

Is It ok to leave a detailed message on your answering machine? ()Yes () No

IN THE EVENT OF EMERGENCY

Who should we contact? _____ Relation _____ Phone #: _____

Who is your Medical Doctor? _____ Phone # _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

- If patient is a minor, I agree to the above statements and authorize the doctors of Front Street Chiropractic to diagnose and treat this patient.

X _____ Date _____
Signature parent/guardian

Ins Co. Phone # _____ Claim # _____

NATURE OF ACCIDENT

Date of Accident _____ Time of Day _____ City/State _____

Were you: ()Driver ()Passenger ()Front Seat ()Back Seat

Number of people in your vehicle? _____ Other Vehicle _____

What direction were you looking? _____ Did you see the accident coming? _____

Were you wearing a seat belt? _____ Did you hit anything in the car? _____ If yes, What _____

Were you knocked unconscious? _____ If yes, how long? _____

Were the police notified? ()Yes ()No

Have you retained an attorney? ()Yes ()No If yes, name: _____

In your own words, please describe the accident: _____

What are your present complaints and symptoms? (Please include a description of the pain and its location) _____

Drs. Notes

On a scale of 0-10 please rate your pain (0=no pain, 10=extreme pain) _____

Did you have any physical complaints BEFORE the accident? ()Yes ()No If yes, please describe: _____

Do you have any previous illness, injury, or congenital (from birth) factors which may relate to this problem?

()Yes ()No If yes, please describe _____

Please describe how you felt: During the accident _____

Immediately after the accident: _____

Later that day _____

The next day _____

Have you ever been involved in an accident before? ()Yes ()No If yes, please describe _____

Have you been treated by any doctor since the accident? () Yes () No If yes, whom? _____

Were x-rays taken? () Yes () No Was medication prescribed? () Yes () No

What activities have been restricted as a result of this injury? _____

Since this injury, are your symptoms: () Improving () Worse () Same

Have you lost time from work as a result of this accident? () Yes () No

Do you have a prior history of similar complaints? _____ If yes, dates, prior treatment, results, etc. _____

Drs. Notes: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- Headache Irritability Numbness in toes Face Flushed Feet Cold
- Neck Pain Chest Pain Shortness of Breath Buzzing in Ears Hands Cold
- Neck Stiff Dizziness Sleeping Problems Loss of Balance Stomach Upset
- Fatigue Depression Head seems too heavy Fainting Constipation
- Back Pain Tingling in arms Light bothers eyes Loss of Smell Diarrhea
- Nervousness Tingling in Legs Loss of Memory Loss of Taste Fever
- Tension Ears ring Numbness in Fingers Cold Sweats _____

PAST MEDICAL HISTORY

Have you ever had any of the following diseases/medical conditions?

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV+/ Aids | <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Emphysema/Glaucoma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes/Tuberculosis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hyperthyroid | |

Please List any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to _____

List previous surgeries/treatment with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

For Women: Are you Pregnant? ()Yes ()No Nursing? ()Yes ()No Date of Last Menses: ___/___/___

Are you taking any of the following medications?

- Nerve Pills Pain Killers (Including Aspirin) Muscle Relaxants Stimulants
- Blood Thinners Tranquilizers Insulin Birth Control Pill Other _____

Please list any medication you are currently taking and what they are prescribed for:

HABITS & ACTIVITY

Do you smoke? ()yes ()no Have you ever smoked? ()yes ()no How many packs per day? _____

Do you drink alcohol? ()Yes ()No Have you ever abused alcohol? Amount/Type _____

Do you drink caffeinated beverages? ()Yes ()No How much and type: _____

Exercise: () None ()Light ()Moderate ()Heavy Do you feel you eat a well balanced diet? () Yes ()No

Are you interested in a complete nutritional profile to assess your specific nutritional needs? ()Yes ()No

Are there any particular activities of daily living that you are having difficulty with due to your presenting complaint(s)? _____

Are there any other health concerns that we did not yet ask about that we should know about?() Yes () No

