Welcome

Patient _____ Date _____

Address _____

_____ e-mail: _____

Phone: Home _____ Work _____ Patient SS# _____

Sex: M F Age _____ Birth date _____ Single Married Widowed Separated Divorced

Occupation _____ Work Activities _____

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Occupation _____

Children's Names & Ages: _____

Whom may we thank for referring you? _____ Have you ever been to a chiropractor before? _____

Who is responsible for this account? _____ Relationship to patient _____

Method of Payment for First Visit: Cash Check Credit Card

List your chief complaints in order of severity:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

Is this condition getting progressively worse? _____ Does the pain spread? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Circle any functions that aggravates or are aggravated by your condition: Walking Driving Working Stairs Digestion Recreation Bowel Movements Sleeping Sinuses Breathing Vision Hearing Lifting Lying Down Smelling Standing Sitting Bending If Female, Menstrual

Do you have headaches? _____ How often? _____ What helps them? _____

Circle all that apply: Migraine Sinus Tension Throb Other _____

List any operations you have had:

1. _____ 2. _____ 3. _____

List any serious illnesses you have had:

1. _____ 2. _____ 3. _____

Mother, Father, Brother, Sister, Children with similar problems? If yes, who: _____

Please circle all symptoms or conditions you have had in the past year

Asthma Allergies Arthritis Diabetes Heart disease Difficulty Sleeping

Forgetfulness Tiredness Constipation Diarrhea Gas Indigestion

Nausea Chest Pain Hearing Loss Excessive weight loss Dizziness

Neck: Pain Stiffness Spasms Grinding/Popping Sounds Pinched Nerve

Shoulders: Pain Stiffness Tension Grinding/Popping Sounds Pinched Nerve

Mid-Back: Pain Stiffness Spasms Pain between Shoulder Blades

Arms: Pain R/L Pins & Needles R/L Numbness R/L Weakness R/L

Hands: Pain R/L Pins & Needles R/L Numbness R/L Weakness R/L

Low Back: Pain Stiffness Spasm Weakness Pinched Nerve

Legs & Feet: Pain R/L Pins & Needles R/L Numbness R/L Weakness R/L Cramps

EXERCISE: None Mild Moderate Heavy Intermittent Daily Comments: _____

WORK ACTIVITY: Sitting Standing Light Labor Heavy Labor Comments: _____

HABITS: Smoking / Packs per day _____ Alcohol / Drinks per week _____

Coffee/Caffeine Drinks / Cups per day _____

High Stress Level / Reason _____

Hobbies / Interests _____

*** WOMEN ONLY:** Is there any chance that you are pregnant? Yes / No Signature: _____

Insurance Co. _____ Address _____

Do you have a deductible? _____ Amount $ _____ Have you met your deductible? _____

Policy # _____ Group # _____

Subscribers Name _____ Birth date _____ SS# _____ Phone _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Potash Chiropractic 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.

Signature _____ Relationship _____ Date _____