

1. PATIENT INFORMATION	
Date _____	
SS/HIC/Patient ID # _____	
Patient Name _____ <small>Last Name</small>	
_____ <small>First Name</small>	_____ <small>Middle Initial</small>
Address _____	
City _____	E-mail _____
State _____	Zip _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____	
Birth Date _____ Time _____ AM/PM	
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years	
Patient Employer/School _____	
Occupation _____	
Employer/School Address _____	
Employer/School Phone (_____) _____	
Spouse's Name _____	
Birth Date _____ Time _____ AM/PM	
SS# _____	
Spouse's Employer _____	
Whom may we thank for referring you? _____	

2. INSURANCE INFORMATION	
Who is responsible for this account? _____	
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name _____	
Birth Date _____ SS# _____	
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
ASSIGNMENT AND RELEASE	
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ <small>Name of Insurance Company(ies)</small>	
_____ 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 authorize the use of my signature on all insurance submissions.	
The above-named clinic/doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.	
_____ <small>Signature of Patient, Parent, Guardian or Personal Representative</small>	
_____ <small>Please print name of Patient, Parent, Guardian or Personal Representative</small>	
_____ <small>Date</small>	_____ <small>Relationship to Patient</small>

3. PHONE NUMBERS	
Cell Phone(_____) _____	Home Phone(_____) _____
Best time and place to reach you _____	
IN CASE OF EMERGENCY, CONTACT	
Name _____	Relationship _____
Home Phone(_____) _____	Work Phone(_____) _____

4. ACCIDENT INFORMATION	
Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	
To whom have you made a report of your accident?	
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp. <input type="checkbox"/> Other	
Attorney Name (if applicable) _____	

5. PATIENT CONDITION	
Reason for Visit _____	
When did your symptoms appear? _____	
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Mark an X on the picture where you continue to have pain, numbness, or tingling.	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____	
Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other	
How often do you have this pain? _____	
Is it constant or does it come and go? _____	
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation	
Activities or movements that are painful to perform <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	



