Patient Information

Name:_______________________________
Date:_________________
Sex: □M □F Age: ____
Date of Birth:____________________
Address:
____
____
Phone Number: ( )_______-________________
Cell Phone: ( )_________-________________
Email Address:____________________________________
Social Security Number:_____________________________
Occupation:_______________________________________
Employer:____
Have you Ever Received Chiropractic Care? □ Yes □ No
If Yes, When? __________________________
Primary Care Physician:___________________________
Address:_______________________________________
Phone Number:__________________________________
Would you like us to send him/her a Chiropractic report? □ Yes □ No

1. Primary Reason for seeking Chiropractic Care

Primary Complaint:
____
____
Secondary Complaint:
____
____
Other contributing complaints:
____
____

2. Chief Complaint

Location of complaint:
____
____
Complaint began when and how?
____
Please Circle the Quality of the Pain: dull aching sharp shooting burning throbbing deep nagging other _______________________________________
Does this complaint/pain radiate or travel (shoot) to any areas of your body? If yes where?
____
____
____
Do you have any numbness or tingling in your body? If yes, where?
____
Grade the pain (0=no pain, 10=worst pain imaginable) 1 2 3 4 5 6 7 8 9 10
How frequently is the complaint present, how long does it last?
____
Does anything aggravate the complaint?
____
Does anything make the complaint better?
____

3. Accident Information

Is this condition due to an accident? □ Yes □ No
Date:_______
Type of accident: □ Auto □ Work □ Home □ Other
To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Worker Comp □Other

Insurance Information

Insurance Company:
____
ID#:_________________________________
Is the patient covered by additional insurance?
□ Yes □No
Insurance Company:
____
ID# ________________________________
Group #:____________________________
Subscriber's Name:
____
Relationship to Insured: Self Spouse Child Other
If you are covered under another persons insurance, please complete
Address of Insured:
____
____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with
____
And assign directly to Christopher Family Chiropractic all insurance benefits, if any, otherwise payable by 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.

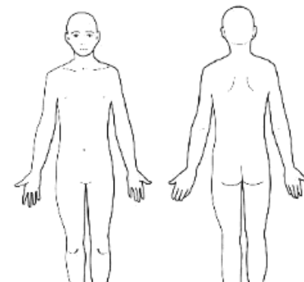
____
Responsible Party Signature

____
Relationship Date

Patient Rights

By initialing the following you are agreeing that you have received and understand the following:
Patients Rights to Privacy ______
Informed Consent for Treatment _______
And Financial Responsibility ______

*** Please mark an "X" on this picture where you continue to have pain, numbness or tingling



Date:_______
Type of accident: □ Auto □ Work □ Home □ Other
To whom have you made a report of your accident? □ Auto Insurance
□ Employer □ Worker Comp □Other
Attorney Name (if applicable):
____