Patient Information Update

Name: _____ **DOB:** _____ **Date:** _____
Address: _____ **City:**_____ **State:**_____ **Zip:**_____
Phone#:_____ **Cell:**_____ **Cell Carrier:** _____ **Email:** _____
Insurance Co: _____ **ID #:**_____
Policy Holder: _____ **DOB:** _____ **SS#:**_____
Employer: _____

Office Policies

Re-exam Policy: If a patient has not been seen in our office for 90 days, they present with a new injury or area of complaint, or if insurance has changed, they will be subject to a re-examination and a subsequent re-exam charge.

NO SHOW POLICY

Due to the high demand of appointments and in order to be respectful of the chiropractic needs of all our patients please be courteous and call or text our office promptly if you are unable to attend an appointment. We always have patients on a cancellation list that need care.

There will be a $25 charge for every appointment missed without proper notification.

I give authorization for you to treat me and bill my insurance_____
Patient Signature

Describe your reason for today's visit: _____ Date of Onset: _____

Describe onset: acute chronic gradual **Cause:** Unknown Accident

Prior pain to this area: None On and off for years Years ago **Side**: left right bilateral

Describe your pain: (Circle one or more) Achy Burning Dull Sharp Stiff Throbbing

Description of Pain: Mild Moderate Severe **Pain level (1-10): _____**

Does the pain radiate to other areas? _____

When is your pain the worst? Morning As day progresses Afternoon Evening During the night No change

What exacerbates this condition? _____ What alleviates symptoms? _____

Do you have numbness? _____ If so, where? _____

Do you have spasms? _____ If so, where? _____

Do you have weakness? _____ If so, where? _____

Do you have limited range of motion? _____ If so, where? _____

Pain with movement? _____ Where? _____