PATIENT PERSONAL/CONFIDENTIAL DATA

Cell Phone: _____ Date: _____

Patient: _____ Date of Birth:_____ SSN:_____

Home Address: _____ City:_____ State:___ Zip: _____

Home Phone: _____ Work Phone:_____ No. of Children_____

Employer: _____ Address:_____

Name of Spouse/Guardian: _____ Date of Birth:_____

Spouse's/Guardian's Employer: _____ Address: _____

How did you learn of this clinic? _____

Emergency Contact: _____Phone:_____ Relationship:_____

Who is responsible for payment? ❑ Self ❑ Spouse ❑ Guardian ❑ Other: _____

PRIMARY INSURANCE:

Name of Insurance: _____

ID No.:_____

Group No.: _____

SECONDARY INSURANCE:

Name of Insurance: _____

ID No.: _____

Group No.: _____

Purpose of this appointment/describe your complaint(s): _____

_____

Date of Injury/Illness: _____Time: _____ ❑ AM ❑ PM Location:_____

How did the injury occur? ❑ Auto ❑ On the job ❑ Other: _____

Please describe the circumstances and what makes the condition(s):

Better: _____

Worse: _____

Other Doctor seen for this condition: _____

Have you been treated by a doctor for any other health condition in the last year? ❑ Yes ❑ No

If yes, please describe: _____

List any medications you are currently taking: _____

PAYMENT POLICY

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Durham Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Durham Family Chiropractic will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable. If I cannot keep your appointment and I do not call or email the office prior to my appointment time I understand that I will be charged a fee of $25.00

Signature of Physician: _____Signature of Patient:_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services he/she deems necessary in my case; and I further authorize the him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Signature of Patient: _____ Parent's/Guardian's Signature:_____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: _____ Date: _____ No: _____

MUSCULOSKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder problems

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

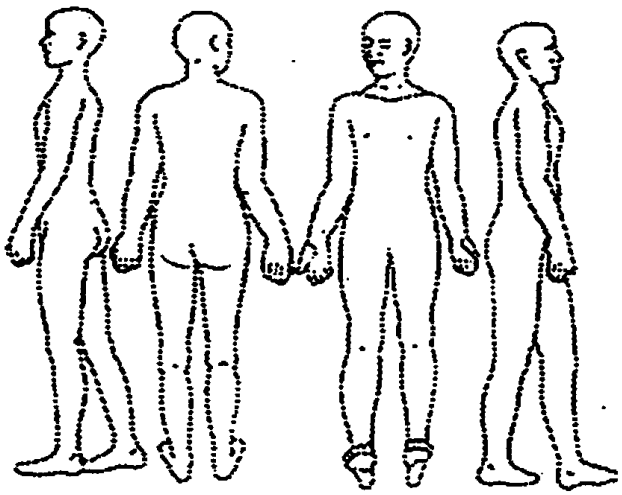
FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ **YES** ❑ **NO**

PLEASE MARK ON THE BODY WHERE YOU EXPERIENCE THE FOLLOWING SYMPTOMS:

P ___ Pain
N ___ Numb
S ___ Spasm
T ___ Tender
H ___ Hypoesthesia
(decrease of sensitivity)



Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of Feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle Jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Smoking
- ❑ Alcohol use
- ❑ Coffee or tea:
- ❑ Drug abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE & THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficulty breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty with speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain

Patient Signature: _____