PATIENT HISTORY

Name:_____ Birthdate:_____ Age:_____ Date:_____

Address:_____ Phone #: (H)_____ (W)_____

City:_____ State:____ Zip:_____ Phone #: (C)_____ e-mail:_____

Social Security #:_____ Spouse/Guardian:_____ # of Children:_____

Occupation: _____ Spouse's Occupation/Employer: _____

Employer's Name/Address/Phone:_____

Name and address of nearest living relative: _____

Doctor Name:_____ Address: _____

Who is Responsible for this Bill? *(circle)* Self WC BC PI MC Other:_____

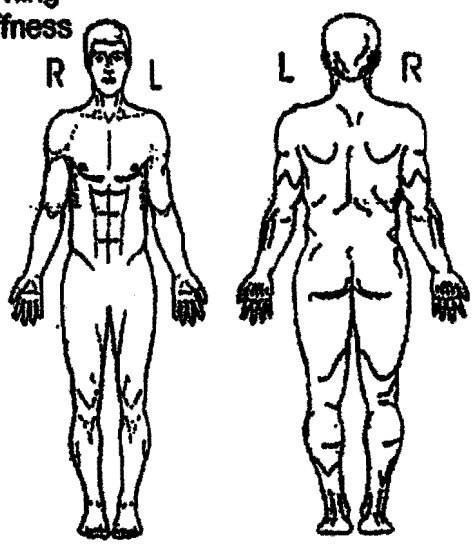
Have you ever been to a Chiropractor for this problem?_____ Other Problems? _____

Who may we thank for referring you to us? _____

List your problems or complaints according to the severity of pain	Date started, or for how long	If you've had the condition before, when?	Did the problem begin with an injury?
1.			
2.			
3.			
4.			

Pregnant?_____

Indicate on picture
P: Pain
T: Tingling
N: Numbness
B: Burning
S: Stiffness



Notes:_____

Pain when: *(circle)* Coughing Sneezing Straining Other_____

Duration of Symptoms/Pain: *(circle)* Intermittent (25% of the time) Occasional (26-50%) Frequent (51-75%) Constant (76-100%)

This Problem: *(circle)* Rapidly Improving · Improving slowly · Fluctuates but getting better · Remains the same · Gradually Worsening · Rapidly Worsening · On and Off

Pain Intensity Now: *(circle)* Comes and Goes, Varies, Does not Vary
No Pain, Mild, Moderate, Fairly Severe, Very Severe; Worst Imaginable

Relieving Factors: Rest Exercise Bracing/Taping Sitting Standing
(circle) Lying Down Hot Packs Cold Packs Other_____

Character: Dull/Ache Sharp/Stabbing Burning Numbness/Tingling
(circle) Throbbing Other/Explain_____

Relation to other body systems or parts: Bowel/Bladder Muscle Weakness/Spasm
Other/Explain_____ No apparent Relationship

Medications: _____

Surgeries: _____

Previous Accidents or Injuries (Explain): _____

_____

Have you lost any time form work or other activities as a result of this condition?
No___ Yes___ From_____ To_____

Check the following conditions/symptoms you may have had or do have now:

____ Alcoholism	____ Depression/Anxiety	____ Headaches	____ Multiple Sclerosis	____ Shortness of Breath
____ Allergy	____ Diabetes	____ Heart Attack	____ Mumps	____ Sinus
____ Anemia	____ Diarrhea	____ Heart Disease	____ Neck Pain	____ Sleeping Problems
____ Atherosclerosis	____ Dizziness	____ High Blood Pressure	____ Nervousness	____ Smoker
____ Arthritis	____ Eczema	____ HIV	____ Neuritis	____ Stiff Neck/Back
____ Back pain	____ Emphysema	____ Low Blood Sugar	____ Numbness	____ Stroke
____ Birth control pill	____ Epilepsy	____ Loss of Balance	____ Pins and Needles	____ Thyroid Problems
____ Cancer	____ Face Flushed	____ Loss of Smell/Taste	____ Pleurisy	____ Tuberculosis
____ Chest pain	____ Fainting Spells	____ Malaria	____ Pneumonia	____ Ulcers
____ Cold/Canker sores	____ Fatigue	____ Measles	____ Polio	____ Venereal Disease
____ Constipation	____ Fever	____ Menstrual Cramps	____ Rapid Weight Change	____ Visual Disturbances
____ Convulsions	____ Gall Bladder	____ Migraine	____ Rheumatic Fever	____ Whooping Cough
____ Cold Hands/Feet	____ Gout	____ Miscarriage	____ Ringing in ears	____ Other

Release of Information & Consent for Treatment

With my signature below, I authorize the release of information from or to Barnot Family Chiropractic, LLC or it's agents, as necessary to file claims to any EAP, insurance provider, attorney or other entity to collect payments for the services rendered to me by Barnot Family Chiropractic, LLC. This authorization includes my consent for treatment, including X-Ray examinations at Barnot Family Chiropractic, LLC. I attest that, to the best of my knowledge, I am not pregnant.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me and that Barnot Family Chiropractic, LLC may prepare any necessary reports and/or forms to assist me in the collection of monies from insurance companies and other entities. I further authorize the use of my "signature on file" for the endorsement of checks made payable to me, for service rendered to me by Barnot Family Chiropractic, LLC. However, I clearly understand and agree that I am personally responsible for all balances due and that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

Patient's Signature_____ Date_____

Guardian or Spouse's Signature_____ Date_____

Information taken by_____ Date_____