

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #: (____) ____ - ____ MAY WE LEAVE A MESSAGE? YES NO

WORK PHONE #: (____) ____ - ____ YES NO

CELL PHONE #: (____) ____ - ____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
 IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____
 ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

ID # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

ID # _____ GROUP # _____

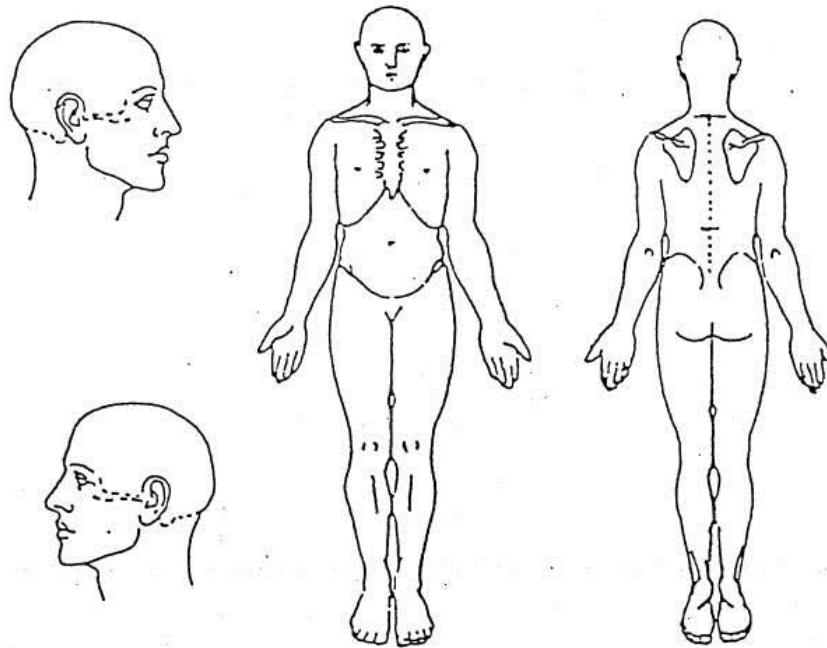
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU HAD THIS CONDITION IN THE PAST? _____ IF YES, WHEN? _____

DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION? _____ IF YES, BY WHOM? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ NO

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

MEDICATIONS:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

SURGERIES/ HOSPITALIZATIONS:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE

CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____

CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ **OCCUPATION:** _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

Please read thoroughly, initial at each section and sign at the bottom. Thank You.

Authorization to Release Information

_____ I authorize Georgetown Chiropractic to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

Information about Possible Risk of Chiropractic Treatment

_____ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure. As with any health procedure complication may arise during treatment. These complications include soreness, muscle or ligament strain, dislocation, fractures, stroke, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Assignment of Benefits

_____ I assign all benefits payable to me for my care to Georgetown Chiropractic. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care.

Authorization to Treat a Minor

_____ I hereby request my doctor at this clinic to perform diagnostic test and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to all other doctors in this clinic and is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and condition of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Georgetown Chiropractic.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE