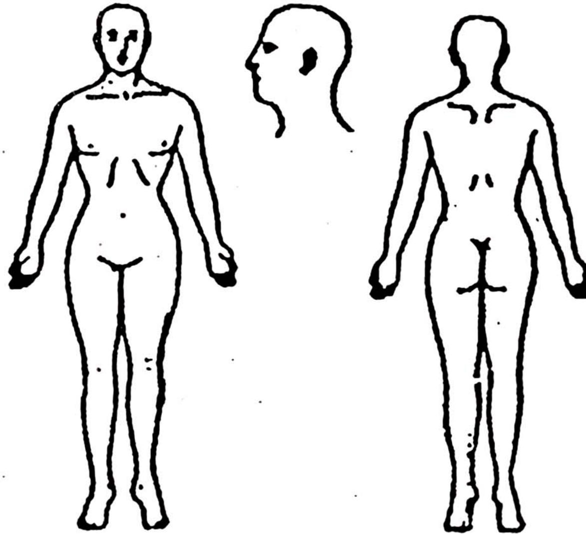
Please mark areas of pain with "P", tingling with "T", numbness with "N", burning with "B" on figures:



Have you suffered from any of the following : (Please check)

___ Headache	___ Irritability	___ Ringing in Ears	___ Stomach Upset
___ Neck Pain	___ Chest pain	___ Buzzing in Ears	___ Constipation
___ Stiff Neck	___ Arm pain	___ HIV positive	___ Cold Sweats
___ Pain between shoulders	___ Clicking jaw	___ Loss of Balance	___ Fever
___ Sleeping problems	___ Shortness of Breath	___ Fainting Spells	___ Heart Trouble
___ Mid Back pain	___ Fatigue	___ Loss of Smell	___ Pace Maker
___ Low Back pain	___ Depression	___ Loss of Taste	___ Arthritis
___ Nervousness	___ Loss of Memory	___ Diarrhea	___ Joint pain/stiffness
___ Tension	___ Head seems too heavy	___ Feet Cold	___ General stiffness
___ Dizziness	___ Light bothers eyes	___ Hands Cold	___ Asthma
___ Digestive Disorder	___ Broken Bones	___ Seizures/convulsions	___ Diabetes
___ Strokes	___ Cancer	___ Ulcer	___ Weight Loss
___ Carpal tunnel syndrome	___ Difficulty walking	___ Difficult chewing	___ Other ___________
___ Loss bowel/bladder control	___ Loss of consciousness	___ Double vision	___________________
___ Pins & Needles; where?	___________________	___ Numbness; where?	___________________

Are you currently seeing any other doctor? If yes, why ____

INSURANCE INFORMATION

Is your condition due to an auto accident of job related injury? _____Yes _____No

Do you have health insurance? ______ Yes ______ No If yes:

Name of Health Insurance Co.____________________________ Policy # ____________________

Secondary Insurance Co. ____________________________ Policy # ____________________

Are you covered by Medicare? ______ Yes ______ No If yes:

Health Insurance #____________________________________

Secondary Insurance ____________________________________

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office 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 this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ________________________________ **Date:** ____________________

If Minor, Guardian or Spouse's Signature: ________________________________