PODEY FAMILY & SPORTS CHIROPRACTIC

Patient Information

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # _____

Occupation _____

Employer _____

Employer Address _____

_____

City State Zip

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS # _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____

Phone Numbers

Home _____ Work _____

Cell Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____

Cell Phone _____

Insurance

Insurance Co. _____

Policy # _____ Group # _____

Subscriber's Name _____

If subscriber is not the patient or spouse, please complete:

Birthdate _____ SS # _____

Relationship to Patient _____

Subscriber's Address _____

_____

City State Zip

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co. _____

Policy # _____ Group # _____

Subscriber's Name _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Podey Family & Sports Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date _____

If no, skip to the next page. If yes, please complete the following:

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

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Patient Condition

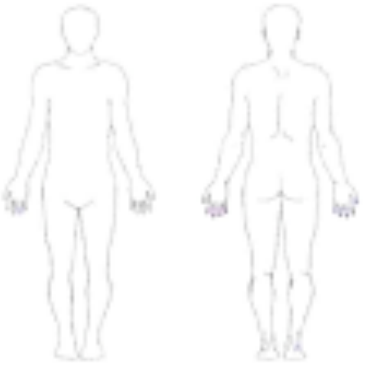
Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark next to any of the following that you have had:

☐ AIDS/HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disk
☐ Herpes
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors, Growths
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Venereal Disease
☐ Whooping Cough
☐ Other _____

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy labor

Habits

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? Yes No If pregnant, due date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

_____

_____

Pharmacy Name _____

Pharmacy Phone _____

Allergies

_____

_____

_____

_____

Vitamins/Herbs/Minerals

_____

_____

_____

_____