# WHAT'S NEW

## 1 one ABOUT YOU

Today's Date: ____/____/____ File #: ____

**Patient Name:** ____
LAST FIRST MI

Mailing Address: ____
( ❑ UNCHANGED )

____
CITY STATE ZIP

Home phone: (____) ____

(____) ____ ____ (____) ____
OFFICE PHONE EXT. CELL PHONE

E-mail Address: ____

**Employer:** ____
( ❑ UNCHANGED )

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

**Marital Status:** ____
( ❑ UNCHANGED )

Spouse's Name: ____

## 2 two INSURANCE INFO

Has any of your Insurance Information changed? ❑ No ❑ Yes
If your insurance info has **not** changed, please continue on to block 3.

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ___/___/___

Insured's Employer: ____

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please provide any **new** Primary/Secondary Ins. cards with this form.

## 3 three MEDICAL INFO

What Medications are you taking? (please include over-the-counter drugs) ____

____

Please list any **new** allergies, diseases, medical conditions, or procedures; include dates when possible: ____

____

____

In event of an emergency, whom should we contact? ____

Relation: ____ Phone #: (____) ____ Cell #: (____) ____

Who is your medical doctor? ____ Phone #: (____) ____

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature: ____ Date: ____/____/____

# BODY CHART

## REASON FOR VISIT

Name: _____ Date: __/__/__ File #: _____

What is your current weight:_____ lbs., and height,_____Ft._____In..

Reason for visit: ❑ Work Accident ❑ Sports Injury ❑ Car Accident ❑ Trauma/Injury ❑ Chronic Pain ❑ Routine Adjustment

Explain what happened:_____

When did condition begin?__/__/__ Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine Have you had this or similar conditions in the past? ❑ Yes ❑ No

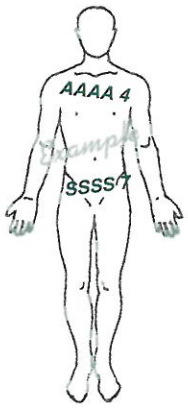
If so, please explain:_____

## SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

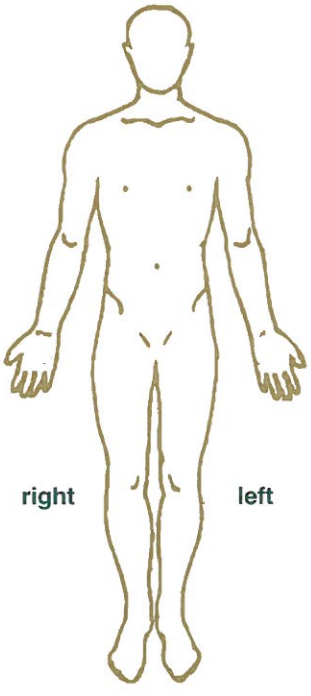
| Description → | Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|---|
| Symbol → | NNNN | PPPP | BBBB | AAAA | SSSS |

◯ Circle any area of pain not represented by a symbol.



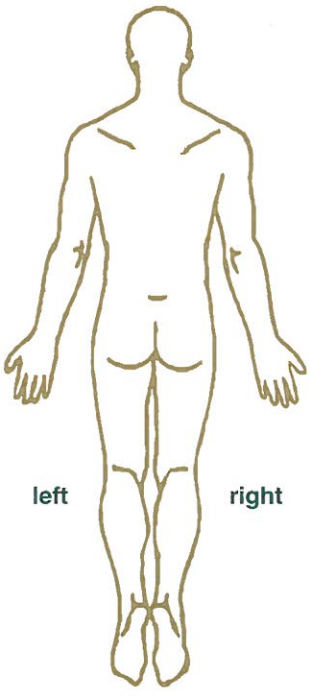

Example

Right



right left

Front



left right

Back

Left

## DOCTOR'S NOTES

_____

_____

_____

_____

_____