Patient Information **Date:**

First Name: _____ MI: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SS # _____ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced
□ Widowed □ Other _____

Date of Birth: _____

Whom may we thank for referring you here:
_____

Insurance Information

Insurance Company: _____
ID#: _____
Group # (if applicable): _____
Subscriber's Name (if different than patient): _____
Relationship to patient: _____

ASSSIGNMENT & RELEASE:
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Nicholson 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 Date

Contact Information

Home Telephone No: ( ) _____

Work Telephone No: ( ) _____

Cell No: ( ) _____

E-Mail: _____

Emergency Contact Person and phone #:
_____

Accident Information

Is condition due to an accident? □ Yes □ No
Date: _____

Type of accident: □ Auto □ Work □ Home □ Other _____

To whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Workers Comp. □ Other

Attorney Name: _____

Health History

Please check any that apply and explain in appropriate area.

Vitals:
Height _____ Weight _____

Surgeries (Back, Neck, Hip, Knee, Shoulder): _____ _____ _____ _____
Dates (s): _____ _____ _____ _____

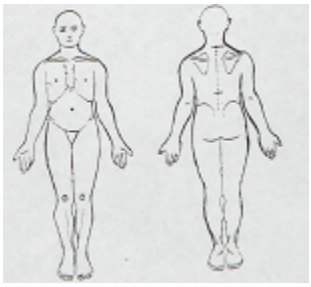
Major Illness::
□ Illness _____ □ Diagnosed when? _____

Family History: (ex: Cancer, Heart Disease, Diabetes ~ for your parents or siblings)

Relationship:	**Problem**:
_____	_____
_____	_____
_____	_____

Social History				**Exercise**
Marital Status	**Smoking**	**Alcohol**	**Caffeine**	□ Never
□ Single	□ Never smoked	□ None	□ None	□ Daily
□ Married	□ Current smoker	□ Casual	□ < 3 drinks/day	□ Weekly
□ Divorced	□ Current everyday smoker	□ Moderate	□ 3 – 6 drinks/day	□ Walks
□ Widowed	□ Former smoker	□ Heavy	□ ≥ 6 drinks day	□ Runs
□ Separated				□ Swims

Neck/Cervical



Indicate symptoms with an X

Cause: Please describe _____
_____
_____
_____

Prior History: □ No □ Yes (Fill out below)

_____

_____

Side it bothers most: □ Left □ Right □ Both

Quality:

□ Achy □ Burning □ Dull □ Sharp □ Stiff
□ Throbbing □ Cramping □ Stabbing □ Numbness
□ Tingling

Description:

□ Mild □ Moderate □ Severe

Frequency (How often does it occur):
(ex. If NOT constant, 1x/day,wk, etc)

□ ___1x/hr □ ___1x/wk □ ___1x/month

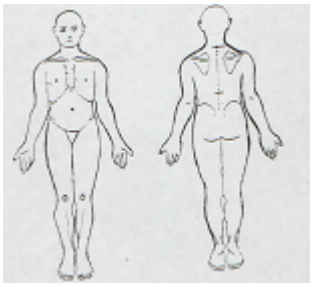
Radiating: □ No radiating pain

Left		Right
□	Shoulder	□
□	Shoulder Blade	□
□	Elbow	□
□	Hand	□

Aggravated By:
□ Nothing
□ Rest
□ Sleeping
□ Walking
□ Working
□ Movement
□ Looking Up
□ Looking Down
□ Rotation of Head
□ Computer Work
□ Driving

Relieved By:
□ Nothing
□ Cold
□ Chiropractic Care
□ Massage Therapy
□ Medication
□ Movement
□ Rest
□ Sleeping
□ Walking
□ Warmth
□ Stretching
□ Change of Position

Low Back/Lumbar



Indicate symptoms with an X

Cause: Please describe _____
_____
_____
_____

Prior History: □ No □ Yes (Fill out below)

_____

_____

Side it bothers most: □ Left □ Right □ Both

Quality:

□ Achy □ Burning □ Dull □ Sharp □ Stiff
□ Throbbing □ Cramping □ Stabbing □ Numbness
□ Tingling

Description:

□ Mild □ Moderate □ Severe

Frequency (How often does it occur):
(ex. If NOT constant, 1x/day,wk, etc)

□ ___1x/hr □ ___1x/wk □ ___1x/month

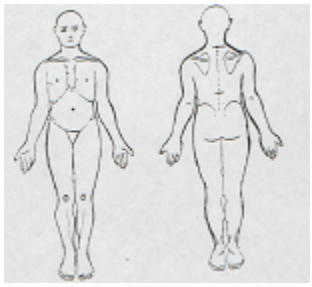
Radiating: □ No radiating pain

Left		Right
□	Buttock	□
□	Back of Leg	□
□	Front of Leg	□
□	Below Knee	□
□	Foot	□

Aggravated By:
□ Nothing
□ Driving
□ Lifting
□ Movement
□ Resting
□ Sleeping
□ Sitting
□ Standing
□ Walking
□ Working
□ Coughing/Sneezing/Straining
□ Lying down
□ Computer work
□ House chores
□ Exercise
□ Stairs
□ Driving

Relieved By:
□ Nothing
□ Cold
□ Chiropractic Care
□ Massage Therapy
□ Medication
□ Movement
□ Rest
□ Sleeping
□ Walking
□ Warmth
□ Stretching
□ Change of Position

Mid Back/Thoracic



Indicate symptoms with an X

Cause: Please describe _____
_____
_____
_____

Prior History: □ No □ Yes (Fill out below)

_____

_____

Side it bothers most: □ Left □ Right □ Both

Quality:

□ Achy □ Burning □ Dull □ Sharp □ Stiff
□ Throbbing □ Cramping □ Stabbing □ Numbness
□ Tingling

Description:

□ Mild □ Moderate □ Severe

Frequency (How often does it occur):
(ex. If NOT constant, 1x/day,wk, etc)

□ ___1x/hr □ ___1x/wk □ ___1x/month

Radiating: □ No radiating pain

Left		Right
□	Shoulder Blade	□

Aggravated By:
□ Nothing
□ Rest
□ Sleeping
□ Walking
□ Working
□ Movement
□ Coughing/Sneezing/Straining
□ Reaching
□ House chores
□ Exercise
□ Driving

Relieved By:
□ Nothing
□ Cold
□ Chiropractic Care
□ Massage Therapy
□ Medication
□ Movement
□ Rest
□ Sleeping
□ Walking
□ Warmth
□ Stretching
□ Change of Position

Patient Name: _____ D.O.B. _____ Date: _____

Ethnicity (Check one):*

Hispanic or Latino Asian TWO or more apply

Black/African American White Other

Native Hawaiian/Pacific Islander American Indian/Alaskan Native

Preferred Language (check ONE):*

English French Italian

Spanish Tagalog Other

Mandarin German

Cantonese Japanese

Medication #1, Please list 1.) Medication NAME, 2.) # of REFILLS 3.)QUANTITY per prescription 4.) STRENGTH 5.) FORM (tablet, capsule) and 6.) DOSAGE instruction. If none, please choose “none”.

Medication #2, Please list 1.) Medication NAME, 2.) # of REFILLS 3.)QUANTITY per prescription 4.) STRENGTH 5.) FORM (tablet, capsule) and 6.) DOSAGE instruction. If none, please choose “none”.

Medication #3, Please list 1.) Medication NAME, 2.) # of REFILLS 3.)QUANTITY per prescription 4.) STRENGTH 5.) FORM (tablet, capsule) and 6.) DOSAGE instruction. If none, please choose “none”.

Are you allergic to any medications?*

No Yes

If "yes" please list Medication and Symptoms of allergy*

_____ _____

Have you been diagnosed with any of the following? (check all that apply)

Asthma Cardiovascular Disease High/Low Cholesterol Diabetes High Blood Pressure

Select all of the following that apply to complete this statement: I SMOKE_____.

Everyday Former Smoker I have never smoked

What is your preferred method of contact?*

Phone call to Cell Phone call to Home

Phone call to Work Mailing Address