AGOURA FAMILY CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

ACCOUNT #:_____INSURANCE COMPANY_____

In order to better serve you, *please print clearly and fill in the following information completely.* Thank you!

Is your visit today related to an accident or work injury? *YES* *NO*

(*if you answered yes, please see the receptionist immediately!)

DATE_____

NAME:_____Home Phone:_____

Address:_____ Work Phone:_____

City:_____State/Zip:_____ Cell Phone:_____

Drivers License#:_____Social Security #:_____-_____-____

E-Mail Address:_____ Age:_____ Date of Birth: _____/_____/_____

Occupation:_____Employer:_____

Employer's Address:_____

Marital Status: S M D W Spouse's Name:_____

Name of Nearest Relative:_____Phone #:_____

**Person Responsible for Billing:_____

Address:_____City:_____

State:_____ Zip:_____Phone #:_____

Medical History:

1. Please describe your present complaint(s) and how it began:_____

_____

2. Date the problem began: _____/_____/_____
3. How bad is your pain? (0=no pain, 10=severe pain) 0 1 2 3 4 5 6 7 8 9 10
4. Check all symptoms that apply to you:

___Gripping ___Tingling ___Shooting ___Aches ___Sharp/Stabbing ___Throbbing

___Numbness ___Soreness ___Weakness ___Burning ___Dull

___Other (please describe):_____

5. How often are your symptoms present?

___Constantly ___Frequently ___Occasionally ___Intermittently

6. What makes the problem worse?

___Nothing ___Lying Down ___Walking ___Standing ___Sitting ___Movement ___Exercise ___Other (please describe):_____

7. Since it began, is your problem: ___Improving ___Getting Worse ___No Change
8. Can you perform your daily home activities? ___Yes ___Yes, with help ___Not at all
9. How often do you exercise? ___Almost Daily ___Occasionally ___Sometimes ___Not at all
10. Describe your job requirements: ___Mainly Sitting ___Light Labor ___Heavy Labor
11. Describe your stress level: ___None ___Mild ___Moderate ___High ___Severe
12. What treatments have you had for this condition in the past?

___Surgery ___Injections ___Medications ___Therapies ___Other:_____

13. Doctor's seen?_____
14. Have you had X-Rays, an MRI or any other test for this condition? YES NO
15. Please list current medications that you take: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that this office will bill my health plan as a courtesy to me. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree, that in the event of default in payment of an amount due and if the account is placed in the hand of an agency or attorney for collection or legal action, I am to pay an additional charge equal to the costs of these services. I authorize the release of medical records to document my treatment if needed. Furthermore, I understand that if I suspend or terminate my case and treatment, any fees for professional services rendered to me will be immediately due and payable. I will inform the office of any changes to the above information.

Referred by:_____

Patient/Parent/Guardian Signature:_____Date:_____/_____/_____