PLEASE TELL US ABOUT YOURSELF

First Name _____ MI _____ Last Name _____

Age _____ Date of Birth _____ Male _____ Female _____

Address _____

City _____ State _____ Zip _____

Email _____ SSN# _____

Cell # _____ Home # _____ Work # _____

Circle Preferred method of Contact: Email Cell Home Work

Referred by (Name, address, contact info _____

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Job Duties _____

EMERGENCY CONTACT WHO SHOULD WE CONTACT IN CASE OF EMERGENCY

Name _____ Contact Number _____ Relationship _____

Name _____ Contact Number _____ Relationship _____

PLEASE TELL US:

Reason for your visit:_____

When did you notice your symptom(s) first appear? _____

Is this symptom(s) getting progressively worse, circle one? YES NO Unknown NA

Mark an X on the locations of symptom(s). Is it PAIN, NUMBNESS, TINGLING or OTHER?

If other, describe_____

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

Type of Pain (circle all that apply) Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

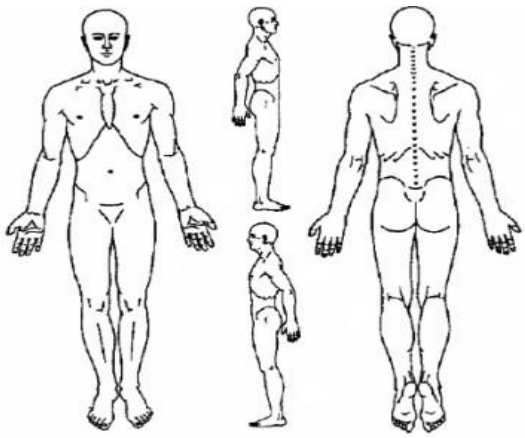
Is this pain constant or does it come and go? _____

Does Heat or Cold or pressure make it better?_____

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? Circle all that apply.

Medications Surgery Chiropractic Physical Therapy Acupuncture None Other

Name and Address of Doctor(s) who have treated you for your condition _____

_____

_____

Date of Last: Physical Exam_____ Chiropractic Tx_____ Acupuncture Tx:_____

Circle to indicate if you have or had any of the following conditions:

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

Are you pregnant? No Yes Due Date _____

Please describe your family history from the list above

Mother _____

Father _____

Sibling _____

Grandparents _____

Other _____

EXERCISE Please circle one: None Moderate Daily Heavy Type of Activity _____

HABITS Write NA if it does not apply. Smoking: Packs/day _____ Alcohol: Drinks/Day _____ Coffee/Caffeine: Drinks/Day _____

High Stress Level: Reason _____

INJURIES / SURGERIES you have had, description, and date:

Falls: _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Medications: _____

_____

_____

Allergies _____

_____

Vitamins/Herbs/Minerals: _____

_____

HealthSpring
Chiropractic

INSURANCE INFORMATION

Insurance Carrier _____ Insurance Plan _____ Contact Number _____

Group Number _____ Policy Number _____

Primary Care Physician _____ Contact Number _____

Address _____ City _____ State _____ Zip _____

ASSIGNMENT OF INSURANCE INFORMATION AND BENEFITS

I hereby authorize the insurance carrier listed above to make payments directly to HealthSpring Chiropractic and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify HealthSpring Chiropractic; otherwise I will be responsible for payment.

Last Name _____ First Name _____ Date _____

Patient Signature _____