

Have you been treated by a chiropractor before? No Yes

Please list current medications: _____

Please list any known allergies: _____

Please list previous surgeries: _____

Please list significant injuries (sprain, strain, fracture dislocation, etc.) _____

How did you hear about our office? _____

General Information

Legal Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ S.S.N.: _____

Occupation: _____ Employer: _____

Insurance Company Name: _____

Member Services Phone #: _____ I.D. # _____

Group/Plan #: _____

Name of Insured (if different from patient): _____ S.S.N. _____

Date of Birth: _____ Phone: _____ Employer: _____

Contacting Your Physician

As a courtesy, with your permission, we may submit a report of your present condition to your primary care physician or referring physician.

Yes, you have my permission to submit a report of my present condition to my physician.

No, you do not have my permission to submit a report of my present condition to my physician.

If yes, please provide the following:

Name of physician: _____

Address: _____ City, State, Zip Code: _____

Telephone Number: _____ Fax Number: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to City Center Chiropractic and Rehabilitation 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

NAME: _____

DATE: _____

Current Complaints

What is the reason for your visit today? _____

When did this condition first appear? _____

Cause of condition: _____

Is the condition getting better, worse or staying the same? _____

Have you had anything like this before? No Yes If Yes, how often? _____

Is the pain: Constant On and off If on and off, each episode lasts: _____

Does the pain radiate? No Yes If Yes, to which part of your body? _____

Does this condition interfere with: Work Sleep Daily routine Recreation

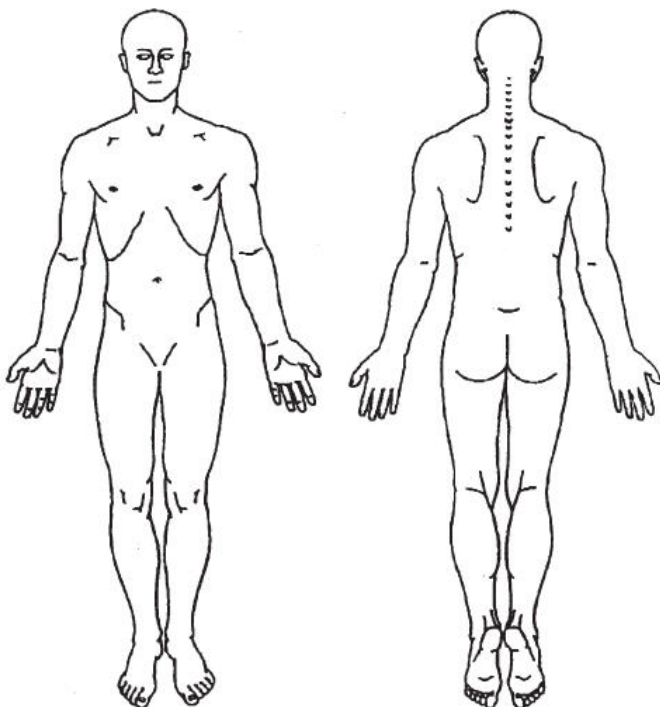
What makes your condition feel better? _____

What makes your condition feel worse? _____

Please list activities that are painful or difficult to perform due to this condition: _____

Describe previous treatment or self care: _____

**Please mark the areas of injury or discomfort
on the diagrams below**



**Please rate your pain on the scale below
by circling the appropriate number
(0 = no pain, 10 = worst pain imaginable)**

Pain Currently

0 1 2 3 4 5 6 7 8 9 10

Pain at its Worst

0 1 2 3 4 5 6 7 8 9 10

Pain Typically

0 1 2 3 4 5 6 7 8 9 10