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:_____ email:_____ _____

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: _____

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, which includes deductibles, co pays and co insurance amounts. 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? _____

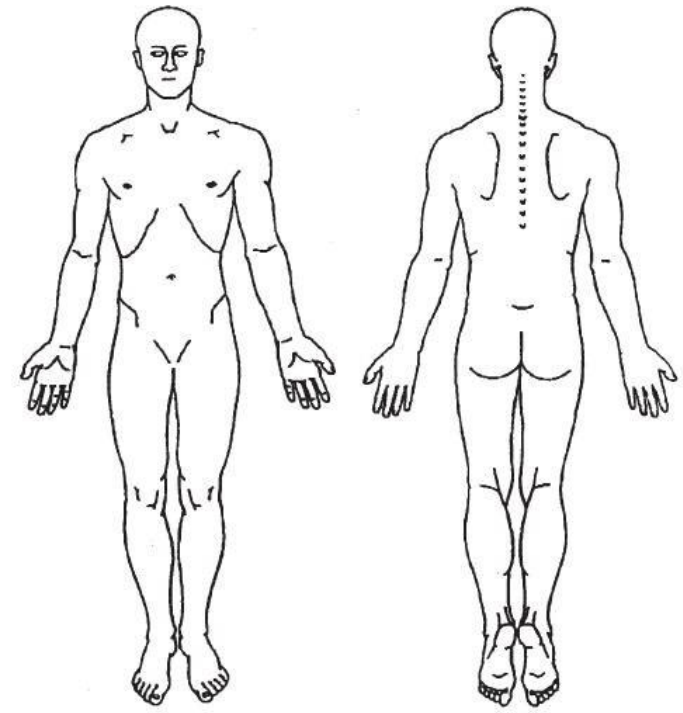
Please list activities that are painful or difficult to perform due to this condition: _____

_____

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