

Patient Contact Information:

Last Name: _____ **First:** _____ **Initial:** _____ **Home Phone:** _____
Nick Name: _____ **Cell Phone:** _____
Address: _____ **Work Phone:** _____ **Ext:** _____
 City: _____ State: _____ Zip: _____ **Email:** _____
Birth Date: _____ **Gender:** (Male Female) **Marital Status:** (S M W D Partnered)
Driver's License #: _____ **State:** _____ **SSN:** _____
Occupation: _____ **Employer:** _____
Whom may we thank for referring you? (Insurance Phone Book Web Search Drive By Other: _____)

Partner/Parent/Guardian/Emergency Contact:

Name: _____ **Relationship:** _____
Address: _____ **Cell Phone:** _____
 City: _____ State: _____ Zip: _____ **Home Phone:** _____
Work Phone: _____

Patient Symptoms:

Is your condition due to an accident that that resulted from an automobile or work related injury? (No Yes)

Please explain the primary reason for your appointment, specific areas of pain, discomfort and all recent injuries: _____

When did your symptoms first appear _____

What caused your condition? _____

Over the past: (Days _____ Weeks _____ Months _____ Years _____)

My condition has been getting: Gradually Worse Rapidly Worse Staying About the Same Getting Better

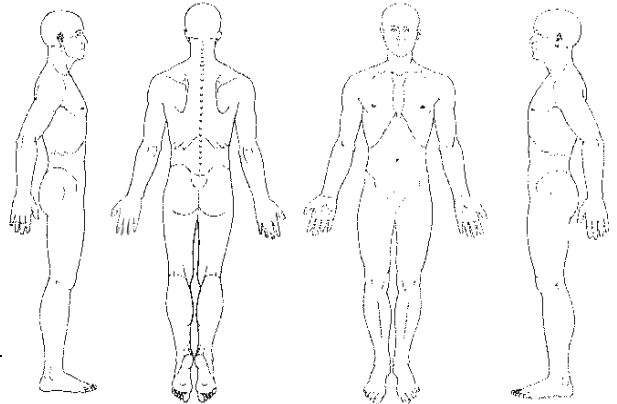
Activities or movements painful to perform: Sitting Standing Walking Bending Lying Down Other: _____

Interferes with your: Work Sleep Daily Routine Recreation

I would describe my pain as: (circle as many as apply)

CONSTANT	FREQUENT	INTERMITTENT	OCCASIONAL
VERY SEVERE	SEVERE	MODERATE	DULL
STABBING	SHARP	ACHING	MILD
BURNING	TINGLING	THROBBING	NUMBNESS
SHOOTING	STIFFNESS	SWELLING	OTHER: _____

PLEASE INDICATE AREAS OF DISCOMFORT



What is your pain on a scale from 1(least) to 10 (severe) _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

I have tried the following solutions for this problem: _____

New to Chiropractic: (No Yes) Previous Chiropractic Care: (No Yes)

Dr: _____ When? _____

For treatment of: _____

Was there a specific treatment that was successful? _____

Present Family Doctor: _____ Phone Number: _____

Date of last physical exam: _____ Blood test: _____ Urine test: _____ Spinal exam: _____

MRI / CT scan / Bone scan: _____ Dental x-ray: _____ Spinal x-ray: _____ Other x-ray: _____

Other Doctors consulted for these health problems:

Dr. Name: _____ When: _____

Diagnosis: _____ Treatment: _____

How long did you see the Doctor? _____ How frequently? _____

Results: _____



Exercise/or Work Level:	Exercise:	Lifestyle:	Family:
<input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Other: _____	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light lifting to 20# <input type="checkbox"/> Heavy lifting +20# <input type="checkbox"/> Swimming <input type="checkbox"/> Biking <input type="checkbox"/> Jog/Run <input type="checkbox"/> Yoga	<input type="checkbox"/> Smoking (Pack/Day: _____) <input type="checkbox"/> Coffee/Caffeine (Cups/Day: _____) <input type="checkbox"/> Alcohol intake (Drinks/Week: _____) <input type="checkbox"/> High Stress (Reason: _____) <input type="checkbox"/> Other: _____	# Infant(s) under 2: _____ # Children: _____ # Care giver for: _____

Current Medication:	Specific Medications:	Adverse Side Effects or Allergies:
<input type="checkbox"/> No <input type="checkbox"/> Yes Prescription Pain Relievers/Anti-Inflammatory: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Over the counter Pain Relievers: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Pressure/ Heart /Insulin: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Stomach/Reflux/Antacid: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Vitamins/Herbs/Minerals: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Nerve/Muscle Relaxants/Anti-Depressants: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Novocain/Cortisone: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Antibiotics: _____		

Injuries/Surgery:	Date/Year:	Description:
Falls/Accidents: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Head Injuries: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Broken Bones/Dislocations: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Previous Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Surgeries: <input type="checkbox"/> Head <input type="checkbox"/> Neck/Throat <input type="checkbox"/> Back <input type="checkbox"/> Abdominal <input type="checkbox"/> Chest / Heart / Lungs <input type="checkbox"/> Other: _____		

Financial Responsibility and Insurance Information: *Please give your insurance card and photo ID to the front desk to copy*

Who is responsible payment? Self Other: _____ (Relationship to patient): _____

Primary Insurance Company: _____
 Subscriber's Name: _____ Relationship to Patient: _____ Birth Date: _____

Secondary Insurance Company: _____
 Subscriber's Name: _____ Relationship to Patient: _____ Birth Date: _____

Signature of Fact, Receipt of Notice Privacy Policies, Acknowledgement of Insurance Assignment and Release:

To the best of my knowledge and ability, I have provided true and complete information. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing below I authorize the doctor, his designated staff and/or insurance company to release any information required for processing insurance claims. I assign any and all appropriate insurance benefits be paid directly to Dr. Bahm/Pine Lake Chiropractic Clinic, P.S. for services rendered.

I have received and reviewed, or had the opportunity to review, and understand and agree to the *Notice of Privacy Practices of Pine Lake Chiropractic Clinic, P.S.*, which describes the Practice's policies and procedure regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

X _____
Signature of Patient or Parent/Guardian Relationship to Patient _____

_____ Date _____
Printed Name Date

Consent for Treatment of Minors or Dependents:

By my signature below, I hereby authorized Pine Lake Chiropractic Clinic, P.S. and their designated staff to administer care to my child or dependent as they deem necessary.

X _____
Signature Parent or Guardian Date _____

