

Complaint history – continued

Are you currently taking any medications? Yes No

If yes, please describe

Were you previously treated for an earlier occurrence of this same condition? Yes No

If yes, by whom? MD Chiropractor Physical Therapist Other

What were the approximate dates, type of treatment and the results?

What is your physical activity at work?

Mostly sitting Light manual labor Moderate manual labor Heavy manual labor

Do you exercise?

No regular exercise 1-2 times a week 3-4 times a week 5-7 times a week

Cardiovascular Stretching Weight machine Free Weights Sports:

What is your present general stress level?

No stress Minimal stress Moderate stress Greatly stressed

Is your problem affecting your ability to work or do other routine daily activities?

No effect Have some limited physical restrictions, but can function

Need some assistance with daily activities Cannot work

Cannot function without assistance Totally disabled

Past or present symptoms, conditions or habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Arm / Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Condition	<input type="checkbox"/>	<input type="checkbox"/>
Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney / Bladder Problem	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Upper Leg or Hip	<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness / Lump	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Lower Leg or Knee	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Ankle or Foot	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Swelling / Stiffness of Joints	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
General Prolonged Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Condition	<input type="checkbox"/>	<input type="checkbox"/>
Condition of Uterus / Ovaries	<input type="checkbox"/>	<input type="checkbox"/>			

Past or present symptoms, conditions or habits – *continued*

Tobacco Use: Past Present Occasional Moderate Heavy
Alcohol Use: Past Present Occasional Moderate Heavy
Caffeine Use: Past Present Occasional Moderate Heavy
Pregnancy: Past Present
Surgical Procedure: Past Present

Please list

Allergies:

Once you print these pages shade in the figures below where you have pain or other symptoms.



Emergency Contact

Relation

Work#

Cell/Home#

Authorization and releases

Name

Consent for Treatment

I, the undersigned, hereby authorize the doctor(s) and whomever they may designate as their assistant to perform diagnostic tests, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient Signature

Date

Witness

Authorization to Release Medical Information

I authorize the doctors(s) to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient Signature

Date

Witness

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company / Insurance Administrator to pay by check, and for it to be mailed directly to: Soft Tissue & Chiropractic Center the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse / sign my name on any and all drafts for payment of my bill.

Patient Signature

Date

Witness

Consent for Treatment of Minor

I hereby authorize the doctor(s) and whomever they may designate as their assistant(s) to perform diagnostic tests, and to administer treatment as they deem necessary for my _____ (*indicate relationship to child. ie: daughter, son, etc.*). (*child's name*) _____.

Parent/Guardian Signature

Date

Witness

Complete all information fields. Select print below and bring to your appointment.