

Welcome

Patient Information

Date _____
SSN _____
Patient Name _____

Address _____
City _____
State _____ Zip Code _____
Age _____ Birth date _____

Please circle one Sex: M F

Married Widowed Single

Minor Separated Divorced

Partnered for _____ years

Occupation _____

Employer _____

Employer's Phone _____

Spouse's Name _____

Spouse's Birth date _____

Whom may we thank for referring you?

Contact Information

Home Phone _____

Cell Phone _____

Other Phone _____

Email _____

Can we contact you my email? Y N

Best time and place to reach you? _____

In case of emergency, contact:

Name _____

Relationship _____

Phone _____

Insurance

Insurance Co _____

Subscriber Name _____

Subscriber Birth date _____

Subscriber SSN _____

Relationship to patient _____

Identification Number _____

Group Number _____ Plan Name _____

Secondary/ Supplementary Insurance

Insurance Co _____

Subscriber Name _____

Subscriber Birth date _____

Subscriber SSN _____

Relationship to patient _____

Identification Number _____

Group Number _____ Plan Name _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Kevin L. Terry D.C. and/or Dr. Tyson L. Terry D.C. all insurance benefits, if any, otherwise payable for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This consent will end upon my being released from care or upon receipt, in writing, of my wishes to terminate consent.

Signature of patient, parent, guardian or personal representative

Please print name of patient, parent, guardian or personal representative

Date

Relationship to patient

Accident Information

Please circle one

Is condition due to an accident? Y N

Type of accident: Auto Work Home Other

To whom have you made a report of your

accident? Auto Employer L&I Other

Patient Condition

Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Y N

Rate the severity of your pain on a scale from 1 to 10:

Type of pain (please circle):

Aching Burning Cramps

Comes and goes Constant Dull Numbness

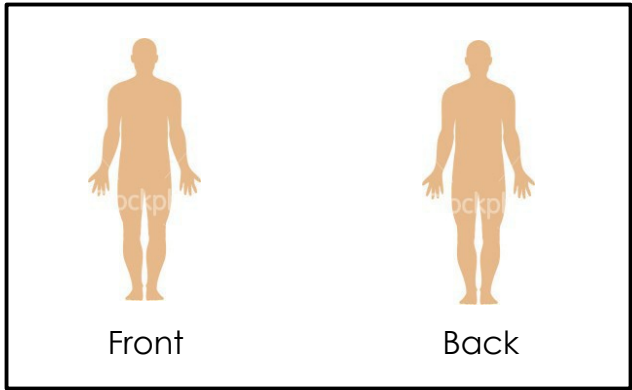
Sharp Shooting Stiffness Swelling Throbbing
 Tingling Other _____

How often do you have this pain? _____

Does it interfere with your (Please circle): Work
 Sleep Daily Routine Recreation

Activities or movements that are painful to perform
 (please circle): Sitting Standing Walking
 Bending Lying Down

Mark an X on the picture where you continue to
 have pain, numbness, or tingling.



Front Back

| | |
|--------------------|----------------------|
| Epilepsy | Fractures |
| Glaucoma | Goiter |
| Gonorrhea | Gout |
| Heart Disease | Hepatitis |
| Hernia | Herniated Disk |
| Herpes | High Blood Pressure |
| High Cholesterol | Kidney Disease |
| Liver Disease | Migraine Headaches |
| Miscarriages | Mononucleosis |
| Multiple Sclerosis | Osteoporosis |
| Pace Maker | Parkinson's Disease |
| Pinched Nerve | Pneumonia |
| Prostate Problems | Prosthesis |
| Psychiatric Care | Rheumatoid Arthritis |
| Rheumatic Fever | STD |
| Stroke | Suicide Attempt |
| Thyroid Problems | Tonsillitis |
| Tuberculosis | Tumor, Growth |
| Ulcers | Vaginal Infections |
| Other _____ | |

Health History

Date of Last: _____

Physical Exam _____

Spinal Exam _____

Dental _____

Spinal/ Chest _____

MRI, CT- Scan, Bone Scan _____

Blood Test _____

Urine Test _____

Please circle to indicate if you have or have had any of the following:

| | |
|-------------------|--------------|
| AIDS/HIV | Alcoholism |
| Allergy shots | Anemia |
| Anorexia | Appendicitis |
| Arthritis | Asthma |
| Bleeding Disorder | Breast Lump |
| Cancer | Cataracts |
| Chemical Dep. | Chicken Pox |
| Diabetes | Emphysema |

Activities and Habits

Exercise (Please circle one)

None Moderate Daily Heavy

Work

Sitting Standing Light Labor Heavy Labor

Habits

Smoking (packs per day) _____

Alcohol (drinks per week) _____

Coffee/ Caffeine Drinks (cups per day) _____

High Stress (reason) _____

Are you Pregnant? Yes No