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

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
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 _____

_____

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