MOVEMENT CHIROPRACTIC

Patient Introduction Form

Date___________________________

First Name_____________________________ Last Name________________________________ DOB_________________

Address____

City____ State_______________ ZIP _________________

Home Phone (_______) _________________Cell (_______) __________________ Work (______)__________________

Email____ Occupation____

Name of Spouse __________________________________ Employer ____

Occupation ____ Work Phone (_________)_____________________________

Nearest Relative in case of emergency _________________ Relationship______________ Phone (_____) ____________

Referred to this office by____

How do you prefer to be addressed (please circle one): Mr. Mrs. Ms. Dr. First Name Other________________

Please provide Driver's License and Health Insurance Card for photocopy

It is usual and customary to pay for services as rendered

I do hereby authorize Movement Chiropractic to furnish my Insurance Company with a full report of physical examination, diagnosis, treatment, prognosis, etc., of myself in regard to my injury and/or illness if requested by them.

I hereby authorize and direct payment to said doctor such sums as may be due on owing him for service rendered. I understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting the doctor's interest, he will not await payment but may declare the entire balance due and payable. These assigned proceeds shall not exceed amounts due and payable to doctor for services rendered.

Patient's Signature ____ Date_____________________

Have you had previous chiropractic care? Y / N Where__________________________________ When ____________

What is your major complaint? ____

____

Other complaints ____

____

How and when did you major complaint first appear? ____

____

How long have you had this condition? ____

Have you had this or similar conditions in the past? Y / N When ____

PCP name, address and phone number ____

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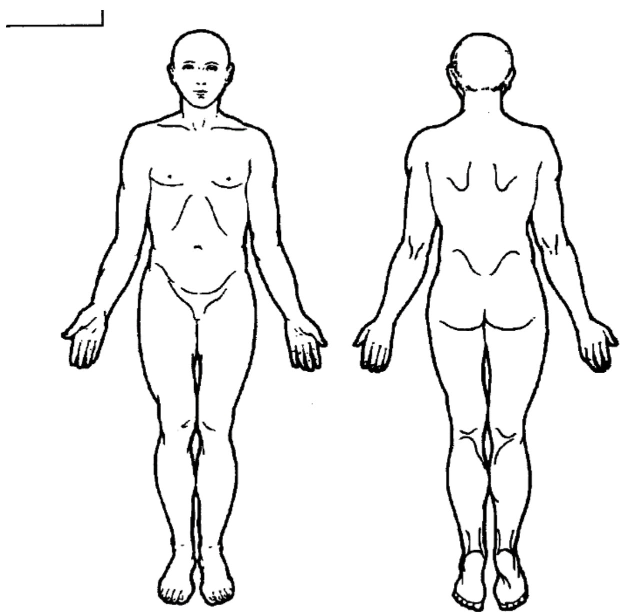
____

Other doctors who have treated this condition ____

Please mark the following diagram with your area(s) or pain(P), numbness(N), tingling (T) on the figure to the right while also noting the severity



No Pain Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Please indicate any limitation in function such as difficulty lifting, bending, standing, walking, sitting, climbing stairs, running, resting in bed, intercourse, or other.

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Please list any sports or physical activities you participate in.

____

____

Do you:

Take any medications? Y / N Type____

Smoke? Y / N Amount_________________________________ Drink? Y / N Amount _________________________________

Any previous surgeries? Y / N Type ____

Family History

Any previous family history of Diabetes, Cancer, TB Heart Disease, Arthritis, High Blood Pressure, Backaches, Stroke, and/or Arteriosclerosis?

Please list:

Family Member	Previous history of
____	____
____	____
____	____

Personal History

Please list any previous auto or personal accidents:

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For Women only

Number of days from beginning of one period to the beginning of the next period ______________________________

Date of last menstrual period _______________________ How many days do you menstruate ___________________

Are you pregnant? Y / N

Additional Information

Any additional information that you would like the doctor to know:

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