MOVEMENT CHIROPRACTIC

Patient Introduction Form

Date_____

First Name_____ Last Name_____ DOB_____

Address_____

City_____ State_____ ZIP _____

Home Phone (_____) _____Cell (_____) _____ Work (_____)_____

Email_____ Name of Spouse_____

Occupation _____ Employer _____

Spouse's Occupation _____ Spouse's 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_____

Insurance guarantor information, please fill out all the information below if you are not the guarantor:

First Name_____ Last Name_____ DOB_____

Relationship to Insured (RTI), please circle one: Self Spouse Child

Address, if different from above_____

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 _____

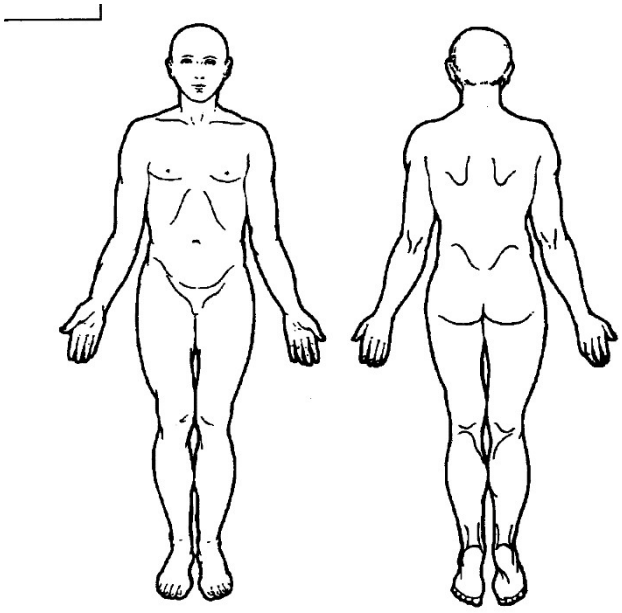
PCP name, address and phone number _____

_____

_____

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.

_____

_____

_____

_____

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:

_____

_____

_____

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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_____