Confidential Patient Information

Name _____ Hm. Phone _____ Wk Phone _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Marital Status (Circle one) M S D W Age _____
Social Security Number _____-_____-_____ Email Address _____
Occupation _____ Employer _____
Work Address _____ City, St., Zip _____
Spouse's Name _____ # of Children _____
Who may we thank for referring you to our office? _____
Have you ever had Chiropractic Care before? Yes □ No □ Date _____

Is this injury or illness related to: Employment □ Auto Accident □
Date: _____ Location: _____
You're Auto Insurance Co.: _____ Phone: _____
Third Party Auto Insurance Co.: _____ Phone: _____

Do you have health insurance? Yes □ No □ Subscribers Social Security Number _____-_____-_____
Primary Insurance Company _____ Phone _____
Secondary Insurance Company _____ Phone _____

All charges are due when services are rendered...

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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Why Chiropractic. People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program. Please circle the box below to indicate your desired care.

RELIEF CARE
You are only worried about the pain, but not what is causing the pain. You will worry about it later when it gets worse. It is like cleaning up the water from a roof leak, but not fixing the leak until the roof is rotted.

CORRECTIVE CARE
You want relief, but you also want to correct the problem before it gets worse. It's like fixing the leak in the roof so you don't have to deal with a rotten roof. Corrective care varies in length of time, but is more lasting.

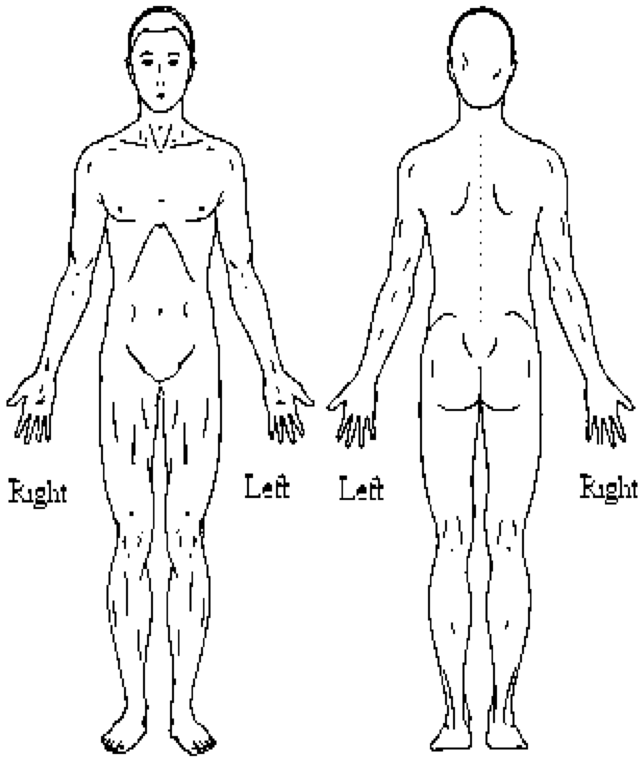
I authorize Fremont Chiropractic to render necessary services to me and I am responsible for all charges incurred.

Patient Signature _____ Date _____

Guardian or spouse authorizing care _____

Thank You For Allowing Us To Serve You!

MARK AN X ON THE DIAGRAM ANYWHERE YOU HAVE PAIN AND DISCOMFORT



Describe symptoms:

_____: ache-burn-stabbing-sharp-numb-tingling-throbbing
Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 (10 being worst pain)
How Often: 25% 50% 75% Constant
How many Days of Week: 1 2 3 4 5 6 7

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When do you think these problems originally started? ____

List any other Chiropractic or Medical Doctors you have seen for these conditions.
____

Please mark any of the following that you have experienced within the past 6 months:

O Headaches
O Neck Pain
O Sleeping Problems
O Low Back Pain
O Nervousness
O Tension
O Irritability
O Dizziness
O Pain between Shoulders
O Neck Stiffness
O Joint Swelling
O Car Accident
O Slip or Fall

O Pain in Hands or Arms
O Numbness in Hands or Arms
O Pain in Legs or Feet
O Numbness in Legs or Feet
O Fatigue
O Abdominal Cramps
O Vision Problems
O Poor Posture
O Lung Problems/Congestion
O Sinus problems
O Ringing in ears
O Asthma
O Allergies

O Chest Pains
O Heart Problems
O High Blood Pressure
O Stroke
O Scoliosis
O Ear Infections
O Diabetes
O Diarrhea
O Constipation
O Heartburn
O Stress
O Acid Reflux
O Ankle Swelling

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure