Patient Information

General Information

Name______________________________ DOB:_____________ SS#________________________ Sex: M F

Address_____________________________ City____________ State_____ Zip_______

Home# (___)-_____-______ Cell Ph# (___) _____-______ Work (____)-_____-______ Ext.____

E-mail address ____

Employer name & Address____

Occupation ______________________________ Marital Status_________

Spouse or Guarantor Name ____________________________ Relationship____________________________

Address (if different)____

Emergency Contact ___________________________________ Ph# ____________________________

Is it possible that you are pregnant? Yes □ No □ Date of Last Menstrual Cycle ______________________

How did you hear about our office? ____

Do you know anyone else that could benefit from Chiropractic care?__________________________________

Chief Complaint

Please describe the condition bothering you now.

____

How long have you had this condition? _________

Have you had a similar condition in the past? Yes □ No □

Is this condition: Getting Worse □ Constant □ Comes & Goes □

Does condition interfere with your: □ Work □ Sleep □ Daily Routine

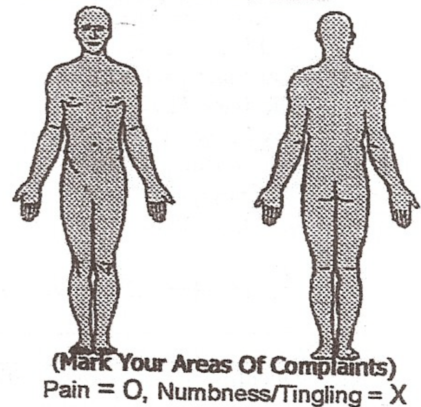
Is present condition due to:

□Auto Accident □Other Accident □Work Injury □ Unknown

Previous Chiropractic Care? Yes □ No □

Have you ever had treatment by another doctor for this condition? □ Yes

□ No



If yes, Doctors' name and address____

If yes, when?__________ Were X-Rays taken?□ Yes □ No Of What ___________________________

Do you have any other problems or concerns you would like addressed?_______________________________

____

Prior Medical History

Who is your family doctor: Name _______________________ Address:_________________

When did you last see your family doctor?_____________ Why ___________________

Are you currently under treatment for any medical condition? Yes □ No □

If yes, please state the condition and treatment being given: _________________

____

When was your last complete physical examination?_____________________________

Have you ever been hospitalized? Yes □ No □

If yes, please state when, where and why__________________________________

____

Have you ever had any major falls, auto accidents or injuries?

If so, please list and explain____

Have you ever had any surgeries? Yes □ No □

If so, please list____

Are you presently taking any prescription medications? Yes ☐ No ☐

If so, Please list____

Please check all the following symptoms, which have continuously been a problem for you:

- ____ Eye Disorders
- ____ Headache/Head Pain
- ____ Double/Blurred Vision
- ____ Neck Pain
- ____ Nervousness/Anxiety
- ____ Shoulder Pain/Stiffness
- ____ Dizziness
- ____ Tennis Elbow
- ____ Tension
- ____ Bursitis
- ____ Fatigue
- ____ Loss of Arm Power
- ____ Sinus Trouble
- ____ Tingling/Numbness/Pain in Hands
- ____ Ear Disorders
- ____ Loss of Grip
- ____ Frequent Sore Throats
- ____ Mid Back Pain
- ____ Asthma/Bronchitis
- ____ Mid Back Tension
- ____ Hay Fever/ Allergies
- ____ Pain In Ribs
- ____ Shortness Of Breath
- ____ Low Back Pain
- ____ Persistent Cough
- ____ Low Back Weakness
- ____ Chest Pain
- ____ Low Back Stiffness
- ____ Rheumatic Fever
- ____ Hip Pain
- ____ Tuberculosis
- ____ Hip Stiffness
- ____ Heart Disease
- ____ Leg Cramps
- ____ High Blood Pressure
- ____ Tingling/ Numbness/Pain in Legs
- ____ Diabetes
- ____ Knee Trouble
- ____ Nausea/ Vomiting
- ____ Foot Trouble
- ____ Constipation
- ____ Tingling/ Numbness/Pain in Feet
- ____ Diarrhea
- ____ Difficulty Or Pain In Sitting
- ____ Abdominal Pain
- ____ Difficulty Or Pain In Standing
- ____ Hemorrhoids
- ____ Difficulty Or Pain In Walking
- ____ Stomach Problems
- ____ Difficulty Or Pain In Bending
- ____ Heart Burn/Indigestion
- ____ Difficulty Or Pain In Sleeping
- ____ Urinary Disorders
- ____ Difficulty Or Pain In Lifting
- ____ Bed Wetting
- ____ Menstrual Disorders
- ____ Arteriosclerosis
- ____ Cancer
- ____ HIV/AIDS
- ____ Disc problems
- ____ Bone disorders
- ____ Carpal Tunnel
- ____ Migraines
- ____ Head Injury
- ____ Arthritis
- ____ Back Surgery
- ____ Stroke
- ____ TMJ

Describe any other Conditions you may have that are not listed above

____

____

Please identify any of these conditions where there is a family history of: ____________________

____

Social History

What recreational activities do you regularly engage in?________________________________

____

Frequency and nature of exercise ____

Frequency and nature of nutritional supplements or vitamins______________________________

____

Please identify any previous occupations ____

I certify that I have read and understand the above information and that I have answered the questions accurately. I understand that the doctor will be relying upon this information and any additional questions that may be asked and that the failure to provide truthful and complete responses may be dangerous to my health and prevent the doctor from being able to properly diagnose and treat my condition. I also authorize my doctor, by signing this document, to request and obtain the records of any treating doctors, tests or studies preformed, including x-rays and/or reports that may be required to diagnose and treat my condition and hereby request that these doctors or facilities produce any such information that may be requested.

Signature ____________________________________ **Date** __________________

Name and relationship of individual providing information if other than patient:

Name ________________________________

Relationship ____________________________

ASSIGNMENT

I hereby instruct and direct my insurance company and/or attorney to pay directly to Spartan Family Chiropractic PC any monies to him for services rendered which would otherwise be payable to me. A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and attorney involved in this case; and hereby release this clinic of any consequence thereof.

FINANCIAL RESPONSIBILIY

I agree to be financially responsible for all charges incurred at Spartan Family Chiropractic PC, including any insurance deductible, co-payments, co-insurance and any services that are not covered for any reason by my insurance company. This includes a $10 fee for any Chiropractic appointments that are missed with out calling prior to your appointment. This fee is not covered by your insurance company.

By signing below I certify that I have read and agree to the information in the above paragraphs.

***Patient or Guardian's Signature*____**

***Today's Date*_________________________________**

MEDICARE ONLY-
ONE-TIME AUTHORIZATION AGREEMENT

Medicare Number_______________________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kevin T. Parker DC or Jamie B. Berk DC for any services furnished to me by either doctor. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature ______________________________ Date____________________