Welcome to Total Athleticare

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____

Address _____

City _____ State ____ Zip_____

Home (_____) _____ Cell (_____) _____

Work (_____) _____ Ext _____

E-Mail: _____

Patient SS#: _____

Sex: ❍ Male ❍ Female Age _____ Birth Date_____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widow

Name of Spouse: _____# of Children:____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____ Phone (____) _____

EMPLOYER INFORMATION

Occupation _____❍ Full Time ❍ Part Time

Employer _____ Phone (____) _____

Address _____

City _____ State ____ Zip_____

PRIMARY CARE PHYSICIAN

Name _____Phone (____) _____

Address _____

City _____ State ____ Zip_____

Whom may we thank for referring you?

_____

INSURANCE INFORMATION

Subscriber's Name _____

Subscriber's Birthdate _____

Subscriber's SS# _____

Relationship to patient _____

Insurance Company Name _____

Insurance Company Phone (_____) _____

Insurance Id # _____

Group # _____

Is the patient covered by additional insurance? _____

We require a copy of your insurance card

ACCIDENT INFORMATION

Is this condition due to an accident? ❍ YES ❍ NO

Date of accident _____

Type: ❍ Auto ❍ Work ❍ Home ❍ Other

To who have you reported your accident?
❍ Auto Insurance ❍ Employer ❍ Worker Comp. ❍ Other

Claim Number _____

Adjuster's Name _____

Adjuster's Phone (___ ____) _____

Attorney Name (if applicable) _____

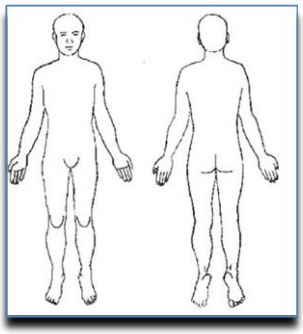
Attorney Phone (_____) _____

We require copies of all injury reports and insurance forms

PATIENT CONDITION

Reason for visit _____ Date symptoms began _____

Please Mark an **X** on the picture where you continue to have pain, numbness, or tingling →



Have you ever had a similar condition? ❍ Yes ❍ No If yes, when: _____

Is this condition getting progressively worse? ❍ Yes ❍ No ❍ Unknown

Rate the severity of your pain on a scale from **1** (least pain) to **10** (severe pain) _____

How often do you have pain? _____ Is the pain constant? _____

Type of pain: ❍ Throbbing ❍ Shooting ❍ Aching ❍ Sharp ❍ Dull ❍ Numbness
❍ Burning ❍ Tingling ❍ Cramps ❍ Stiffness ❍ Swelling ❍ Other

Activities or movements which are painful to perform: ❍Sitting ❍ Standing ❍ Walking ❍ Bending ❍ Lying Down

Does this condition interfere with: ❍ Work ❍ Sleep ❍ Daily Routine ❍ Recreation ❍ Other

What treatment have you already received for your condition?
❍ Chiropractic Services ❍ Physical Therapy ❍ Medications ❍ Surgery ❍ None ❍ Other _____

Please turn over

HAVE YOU EVER SUFFERED FROM ANY OF THESE? *Please check all that apply*

- ❍ Aids/ HIV
- ❍ Alcoholism
- ❍ Allergy Shots
- ❍ Anemia
- ❍ Anorexia
- ❍ Appendicitis
- ❍ Arthritis
- ❍ Asthma
- ❍ Bleeding Disorders
- ❍ Breast Lump
- ❍ Bronchitis
- ❍ Bulimia
- ❍ Cancer
- ❍ Cataracts
- ❍ Chemical Dependency
- ❍ Chicken Pox
- ❍ Diabetes
- ❍ Emphysema
- ❍ Epilepsy
- ❍ Fractures
- ❍ Glaucoma
- ❍ Goiter
- ❍ Gonorrhea
- ❍ Gout
- ❍ Heart Disease
- ❍ Hepatitis
- ❍ Hernia
- ❍ Herniated Disc
- ❍ Herpes
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Kidney Disease
- ❍ Liver Disease
- ❍ Measles
- ❍ Migraine Headaches
- ❍ Miscarriage
- ❍ Mononucleosis
- ❍ Multiple Sclerosis
- ❍ Mumps
- ❍ Osteoporosis
- ❍ Pacemaker
- ❍ Parkinson's Disease
- ❍ Pinched Nerve
- ❍ Pneumonia
- ❍ Polio
- ❍ Prostate Problem
- ❍ Prosthesis
- ❍ Psychiatric Care
- ❍ Rheumatoid Arthritis
- ❍ Rheumatoid Fever
- ❍ Scarlet Fever
- ❍ Stroke
- ❍ Suicide attempt
- ❍ Thyroid Problems
- ❍ Tonsillitis
- ❍ Tuberculosis
- ❍ Tumors, Growths
- ❍ Typhoid Fever
- ❍ Ulcers
- ❍ Vaginal Infections
- ❍ Venereal Disease
- ❍ Vitamin Deficiency
- ❍ Whooping Cough
- ❍ Other _____
  _____

EXERCISE ❍ None ❍ Moderate ❍ Daily ❍ Heavy

WORK ACTIVITY ❍ Sitting ❍ Standing ❍ Light Labor ❍Heavy Labor

HABITS Smoking: Pack/Day_____ Alcohol: Drink/Week _____

Coffee/Caffeine: Cups/Day_____ High Stress Level: Reason _____

What medications/vitamins are you currently taking? _____

Do you have any known allergies? ❍Yes ❍No If yes, please list: _____

Date of last Physical Examination _____ Are you currently pregnant? ❍ Yes ❍ No ❍ N/A

FAMILY HEALTH HISTORY

Condition	Father	Mother	Brother	Sister	Children
Arthritis					
Asthma/Allergies					
Cancer					
Back Problems					
Blood Disorder					
Diabetes					
Disc Problems					
Headaches					
Heart Disease					
High Blood Pressure					
Neck Pain					
Pinched Nerve					
Scoliosis					
Other					

I have read the information and certify it to be true and correct to the best of my knowledge and hereby authorize this office of Chiropractic to provide me with Chiropractic Care, in accordance with this state's statutes. I assign directly to Total Athleticare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Total Athleticare to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature _____ Date _____