Foxworth Chiropractic

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PATIENT INFORMATION

Date_____

Patient_____

_____

Street

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?

_____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient_____

Insurance Co._____

ID#_____ Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

ID#_____Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent(s)) have insurance coverage with_____and assign directly to Foxworth Chiropractic 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 insurance. I hereby authorize the doctor to release all information necessary, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

CONTACT INFORMATION

Home_____ Work_____ Ext_____

Cell _____ Fax_____

Email Address_____

*will not be shared with any other entity under penalty of Federal Law

IN CASE OF EMERGENCY, CONTACT

Name_____

Home phone_____ Relationship_____

Name of Nearest Relative_____

Phone of Nearest Relative_____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Supervisor/Adjuster _____

Phone _____

Attorney Name (if applicable)_____

Phone _____

PATIENT CONDITION

Reason for visit?_____

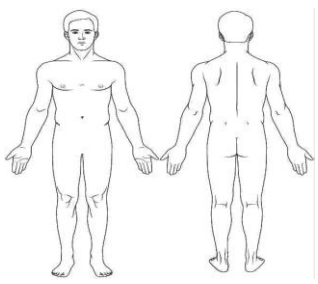
When did your symptoms appear?_____

If long-standing, when did THIS episode begin: _____

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

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

Rate the severity of your pain on a scale from 0 (least pain) to 10 (severe pain)_____



Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other_____

Name of other doctor(s) who have treated you for your condition_____

Have you been told you may need surgery? __Yes __No

By Whom?:_____

What made you finally decide to seek treatment for this condition? (just won't go away, pain, interference with work, family duties, recreation etc.):_____

_____

Which of the following applies: referred by your physician, want to avoid side-effects of medicine, want to avoid surgery, want to treat naturally if possible,

Other:_____

If you receive x-rays at our facility do you want to keep your disc? ____ Yes ____ No

Family Doctor: _____

A report will be sent to your treating or referring physician(s) to keep them informed of your treatment and progress with your authorization.

Please initial: _____ Please provide a report to my physicians _____Please do NOT provide a report to my physicians

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Please circle any conditions below if you now have, or have had them in the past

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

EXERCISE	WORK ACTIVITY	HABITS/OTHER	
___ None	___ Sitting	___Smoking	Packs/Day _____
___ Moderate	___ Standing	___Alcohol	Drinks/Week _____
___ Daily	___ Light Labor	___Coffee/Caffine	Cups/Day_____
___ Heavy	___ Heavy Labor	___ High Stress Level	Reason _____

Are you pregnant? ___Yes ___No Due Date_____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones/Dislocations		
Surgeries		

Medications	**Allergies**	**Vitamins/Herbs/Minerals**