

**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 \_\_\_\_\_

**PHONE NUMBERS**

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 or 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

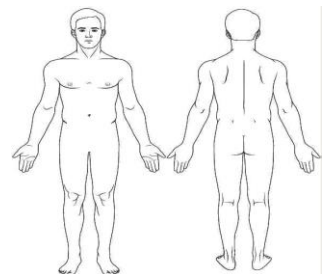
Burning  Tingling  Cramps  Stiffness  Swelling  Other

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.): \_\_\_\_\_

What made you decide to see a Doctor of Chiropractic? (Referred by your physician, want to avoid side-effects of medicine, want to avoid surgery, want to treat naturally if possible, etc.): \_\_\_\_\_

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 Disorders	Hepatitis	Pneumonia	Growths
Breast Lump	Hernia	Polio	Thyphoid
Bronchitis	Herniated Disk	Prostate	Ulcers
Bulimia	Herpes	Problems	Vaginal
Cancer	High Blood Pressure	Prosthesis	Infections
Cataracts	High Cholesterol	Psychiatric	Venereal
Chemical Dependency	Kidney Disease	Care	Disease
Chicken Pox	Liver Disease	Rheumatoid	Whooping
Diabetes	Measles	Arthritis	Cough
	Migraines	Rheumatic	Other: _____
	Headaches	Fever	_____

<b>EXERCISE</b>	<b>WORK ACTIVITY</b>	<b>HABITS/OTHER</b>	
___ 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 _____	_____	_____
<b>Medications</b>	<b>Allergies</b>	<b>Vitamins/Herbs/Minerals</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____