Foxworth Chiropractic

Dr. Drew Cefalu & Dr. Susan Berry

PERSONAL INFORMATION

First Name:_____M.I._____Last Name:_____PreferredName:_____
Address:_____
City:_____ State:_____ Zip:_____
Birthdate:_____/_____/_____ Age_____ Gender: □ Male □ Female
SSN:_____/_____/_____
Primary Phone:_____ Secondary Phone:_____
Email:_____
Occupation:_____
Employer:_____
Marital Status: (check one) □ Single □ Married □ Divorced □ Widowed □ Separated
Children?: □ Yes How Many: _____ □ No Spouse's Name:_____
Emergency Contact:
Name _____ Relationship to patient _____
Primary Phone _____
How were you referred to Foxworth Chiropractic? _____

INSURANCE INFORMATION

Insurance Company _____ ID# _____
Subscriber Name (if different than self) _____ Subscriber Date of Birth_____
Relationship to Patient _____

ACCIDENT INFORMATION

Is condition due to an accident? □ Yes □ No
Type of accident □ Auto □ Work □ Home □ Other
Date of Accident _____
To whom have you made a report of your accident? □ Auto Insurance □ Workers Comp.
Adjuster Name & Company _____ Phone _____
Claim # _____
Attorney Name _____ Phone _____

Verbal Communication Release

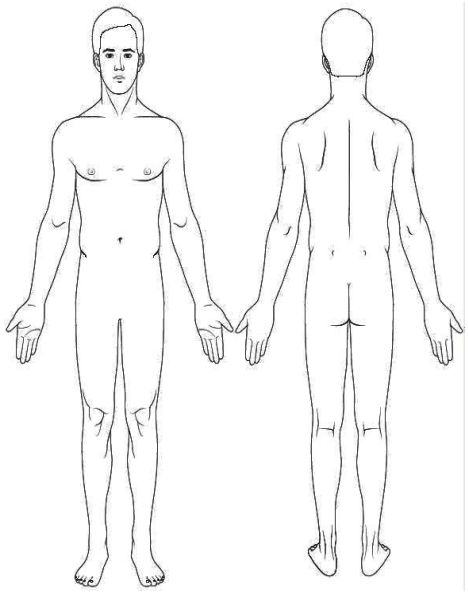
By signing this release, I authorize Foxworth Chiropractic to discuss my health information and billing information, in person or by telephone with the individual(s) and/or organization(s) listed below. I acknowledge that this release is for verbal communication only and does not allow for copies of my medical records to be released.

NAME	RELATIONSHIP	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ Date _____

REASON FOR VISIT

Mark an X on the picture where you are having pain, numbness or tingling.



Chief Complaint _____

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

When was the pain first noticed? _____

Is this condition getting □ Better □ Worse □ Same

Type of pain: □ Sharp □ Dull □ Aching □ Tingling/Numb □ Stiffness

□ Other: _____

How often do you have this pain? □ Constant □ Comes & Goes □ Frequent

What aggravates the pain? _____

What relieves the pain? _____

When is the pain at its worse? □ All Day □ Morning □ Evening □ Intermittent

What treatment have you already received for this condition? □ Medications

□ Surgery □ Physical Therapy □ Chiropractic Services □ None

Please List all Medications and/or Vitamins you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

Please list all surgeries and year of surgery:

_____

_____

_____

_____

PAST ILLNESSES OF YOURSELF AND YOUR FAMILY:

YOU/YOUR FAMILY			YOU/YOUR FAMILY			YOU/YOUR FAMILY	
□	□	HERNIATED DISC	□	□	HIGH BLOOD PRESSURE	□	□ STROKE
□	□	ANEMIA	□	□	KIDNEY DISEASE	□	□ SUICIDE ATTEMPT
□	□	ASTHMA	□	□	LIVER DISEASE	□	□ THYROID DISEASE
□	□	CANCER/TUMOR	□	□	ARTHRITIS	□	□ PINCHED NERVE
□	□	DIABETES	□	□	MULTIPLE SCLEROSIS	□	□ HERNIA
□	□	DRUG ABUSE	□	□	MENTAL ILLNESS	□	□ PARKINSONS
□	□	DEPRESSION	□	□	OSTEOARTHRITIS	□	□ GOUT
□	□	EPILEPSY/SEIZURES	□	□	OSTEOPOROSIS	OTHER _____	
□	□	PACEMAKER	□	□	MISCARRIAGE	OTHER _____	
□	□	HEART DESEASE	□	□	RHEUMATIC ARTHRITIS	OTHER _____	

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:** _____