Welcome

PATIENT INFORMATION

Date_____

Name(last)_____

(first)_____(middle initial)_____

Social Security Number_____

Address_____

City_____

State_____Zip_____

E-mail_____

Sex □ M □ F Age_____

Birthdate_____

□ Married □ Single □ Widowed □ Minor

□ Separated □ Divorced □ Partnered for_____years

Occupation_____

Employer_____

Employer Address _____

_____

Employer/School Phone (____)_____

Spouse's Name_____

Spouse's Employer_____

Whom may we thank for referring you?_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to Dr. Frederick Haines 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature_____

Printed name_____

Date_____ Relationship to patient_____

Phone Numbers

Home Phone (_____)_____

Cell Phone (_____)_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Home Phone(_____)_____

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

Attorney Name (if applicable)_____

Patient Condition

Reason for visit_____When did your symptoms appear?_____

Is the condition progressively getting worse? □Yes □No □Unknown

Mark an X on the picture where you have numbness, pain or tingling----------→

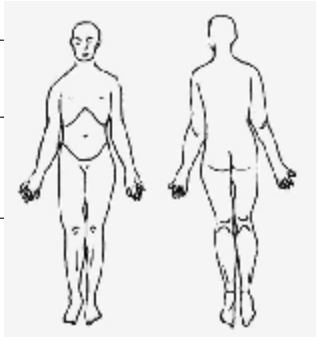
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

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 this condition? ☐Medications ☐Surgery ☐Physical Therapy

☐Chiropractic Services ☐None ☐Other_____

Name and address of other doctor(s) you seen for this condition_____

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_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Diabetes	☐Yes	☐No	Measles	☐Yes	☐No	Arthritis	☐Yes	☐No
Alcoholism	☐Yes	☐No	Emphysema	☐Yes	☐No	Migraines	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Allergy Shots	☐Yes	☐No	Epilepsy	☐Yes	☐No	Miscarriage	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Anemia	☐Yes	☐No	Fractures	☐Yes	☐No	Mononucleosis	☐Yes	☐No	Sexually		
Anorexia	☐Yes	☐No	Glaucoma	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No	Transmitted		
Appendicitis	☐Yes	☐No	Goiter	☐Yes	☐No	Mumps	☐Yes	☐No	Disease	☐Yes	☐No
Arthritis	☐Yes	☐No	Gonorrhea	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Stroke	☐Yes	☐No
Asthma	☐Yes	☐No	Gout	☐Yes	☐No	Pacemaker	☐Yes	☐No	Suicide Attempt	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	Heart Disease	☐Yes	☐No	Parkinson's			Thyroid Problems	☐Yes	☐No
Breast Lump	☐Yes	☐No	Hepatitis	☐Yes	☐No	Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Bronchitis	☐Yes	☐No	Hernia	☐Yes	☐No	Pinched Nerve	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Bulimia	☐Yes	☐No	Herniated Disk	☐Yes	☐No	Pneumonia	☐Yes	☐No	Tumors, Growths	☐Yes	☐No
Cancer	☐Yes	☐No	Herpes	☐Yes	☐No	Polio	☐Yes	☐No	Typhoid Fever	☐Yes	☐No
Cataracts	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Prostate Problem	☐Yes	☐No	Ulcers	☐Yes	☐No
Chemical			High Cholesterol	☐Yes	☐No	Prosthesis	☐Yes	☐No	Vaginal Infections	☐Yes	☐No
Dependency	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Whooping Cough	☐Yes	☐No
Chicken Pox	☐Yes	☐No	Liver Disease	☐Yes	☐No	Rheumatoid			Other_____		

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Consultation

HABITS

☐ Smoking Packs/Day_____

☐ Alcohol Drinks/Week_____

☐ Coffee/Caffeine Drinks Cups/Day_____

☐ High Stress Level Reason_____

Are you pregnant? ☐ Yes ☐No Due Date_____

Injuries/surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Discolorations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name_____	_____	_____
Pharmacy Phone(_____)_____	_____	_____