PRINT OUT AND COMPLETE THIS FORM. BRING IT WITH YOU TO YOUR FIRST APPOINTMENT.

BARNETT CHIROPRACTIC / CHIRO CARE, INC.

Date_____

Patient Number_____

PLEASE CHECK THE TYPE OF CARE DESIRED:

☐ TEMPORARY RELIEF ☐ LASTING CORRECTION

CONFIDENTIAL PATIENT INFORMATION

Name _____ Age _____ Date of Birth_____

Address _____ City_____ State_____ Zip_____

Home Phone _____Cell Phone _____ Email _____

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Spouse _____ Occupation _____

Employer _____ Address _____ Office Phone _____

Patient's nearest relative _____

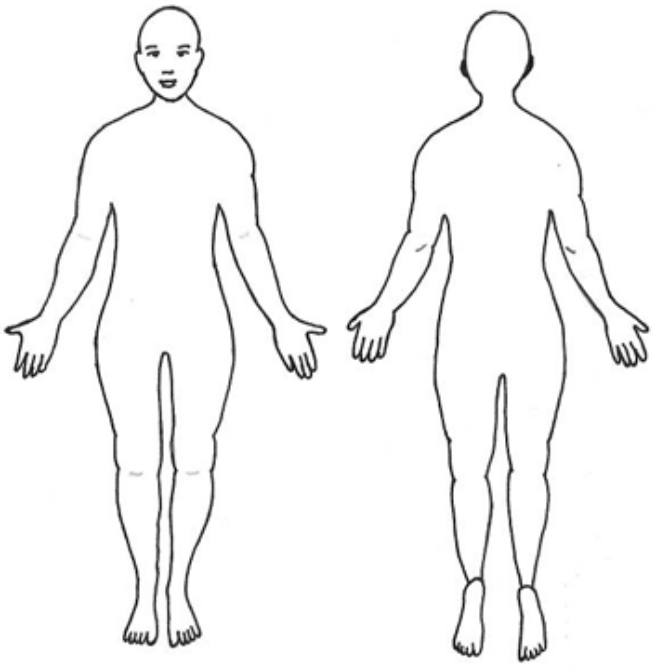
Address _____Date of Last Physical Exam _____

Referred by: ☐ T.V. ☐ Newspaper ☐ Sign & Location ☐ Phonebook ☐ Internet/Website ☐ Facebook ☐ Friend _____

Name of individual that referred _____

If you are in pain please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc.

Complete These Diagrams



MAJOR COMPLAINT
(Please describe only your major problem)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did this condition develop? (What caused it? How did it start?)_____

_____

When was the very first time you were aware of this problem?_____

Have you ever had this problem or similar problem before? If yes, explain_____

_____

Name(s) of other doctor(s) seen for this condition_____

_____

Any medical diagnosis of your complaint?_____

_____

What surgery has been done?_____

Have you been in an automobile accident? ❑ Past year ❑ Past five years ❑ Over five years ❑ Never

IF YOURS IS AN ACCIDENTAL INURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Date of accident:_____ Hours:_____ AM_____ PM_____ Location:_____

How did accident occur? ❑ Auto collision ❑ On-the-job injury ❑ Other:_____

If not an auto collision, please describe the circumstances:_____

_____

Did you report the injury to your foreman or employer? ❑ Yes ❑ No

Did he (they) recommend care at our office? ❑ Yes ❑ No

If auto accident, were you ❑ Driver? ❑ Passenger? ❑ Pedestrian?

If auto collision, were you struck from ❑ Behind? ❑ Right Side? ❑ Left Side? ❑ Front? ❑ Auto was parked

Did your car strike the other(s) involved? ❑ Yes ❑ No Or did the other car strike yours? ❑ Yes ❑ No ❑ Undetermined

As a result of the accident, were traffic citations issued to you? ❑ Yes ❑ No To the driver of the other car? ❑ Yes ❑ No

To the driver of your car? ❑ Yes ❑ No List the extent of the injuries as you know them:_____

_____

_____ Did you require post-accident hospitalization? ❑ Yes ❑ No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

❑ Headache	❑ Irritability	❑ Numbness in Toes	❑ Face Flushed	❑ Feet Cold
❑ Neck Pain	❑ Chest Pain	❑ Shortness of Breath	❑ Buzzing in Ears	❑ Hands Cold
❑ Neck Stiff	❑ Dizziness	❑ Fatigue	❑ Loss of Balance	❑ Stomach Upset
❑ Sleeping Problems	❑ Head Seems Too Heavy	❑ Depression	❑ Fainting Spells	❑ Constipation
❑ Back Pain	❑ Pins & Needles in Arms	❑ Light Bothers Eyes	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins & Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness in Fingers	❑ Ears Ring	❑ Diarrhea	❑ _____

Symptoms other than above _____

Have you lost any days of work? ❑ Yes ❑ No Dates: _____

Name of your insurance company involved: _____

Name of insurance company of person responsible for injuries: _____

Have you been contacted by an insurance adjustor or company representative regarding this claim? ❑ Yes ❑ No

Do you have an attorney who has advised you in this case? ❑ Yes ❑ No Name: _____

Address of attorney: _____ Phone #: _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: _____

Are you insured? ❑ Yes ❑ No Company _____

Insured's Name:_____SS #_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Chiro Care, Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Chiro Care, Inc. will be credited to my account of receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Date _____

Patient's signature _____ Social Security # _____

Parent or guardian signature _____ Social Security # _____

Information taken by _____