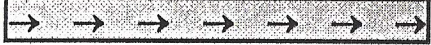


Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**



**Key: A=Ache B=Burning N = Numbness  
P=Pins & Needles S=Stabbing**

When did this Condition BEGIN? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Has it ever occurred before?  Yes  No. When? \_\_\_\_\_

Is the Condition:  Auto Related  Job Related  Home Injury

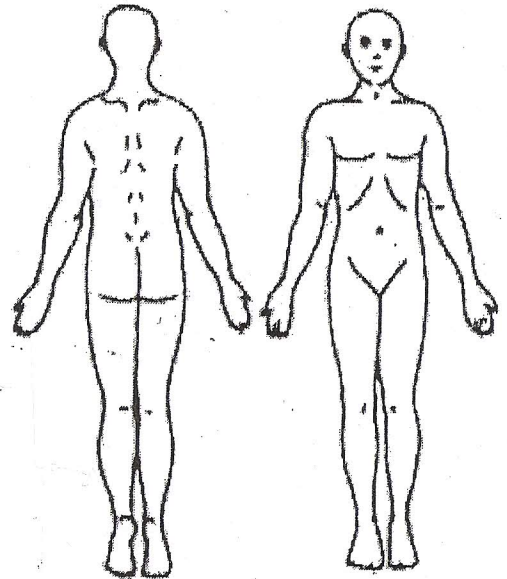
Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am/pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



**Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

**Insurance Information:**

Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es))  Myself ONLY

Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Other (be specific): \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Workers Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?  Yes  No Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ am/pm

Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

Carriers Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_

Claim #: \_\_\_\_\_

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_