a hip joint

417-832-1HIP www.ahipjoint.com

309 S. Jefferson Ave Springfield, MO 65806

How did you hear about us?

- **Referral:**_____
- **Facebook**
- **Website**
- **Other:**_____

Patient name_____ Email_____

Phone number_____ Birthdate ____/____/_____ Sex M / F

Address_____ City_____ State_____ Zip_____

Occupation/Employer_____ Work Phone_____

DESCRIBE YOUR CURRENT PROBLEM & HOW IT BEGAN

(circle where appropriate):

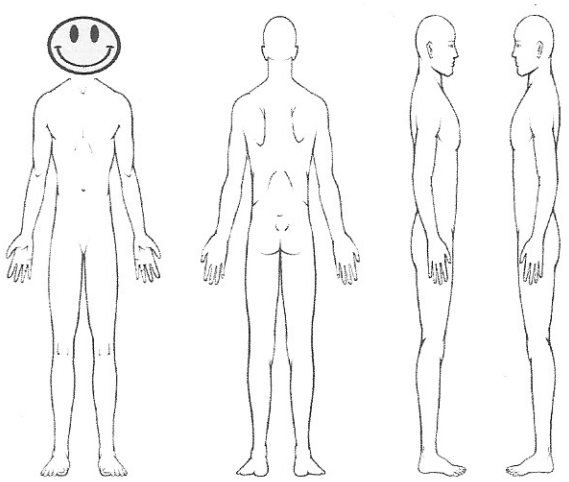
Headache Neck Pain Mid-Back Pain Low Back Pain OTHER

Date problem began: _____

How problem began: _____

Things done to alleviate problem/ describe anything that has made problem worse:_____

Mark an **X** on picture where pain occurs



How do you feel today? Notate Pain (0 being no pain, 10 being unbearable pain): _____

How often are your symptoms present? Circle appropriate response.

Intermittent 0-25% 26-50% 51-75% Constant 76-100%

In the Past week, how much has your pain interfered with your daily activities on a scale of 0-10? _____

Have you had Spinal X-Rays, MRI, or CT Scan for your areas of complaint? List dates if applicable._____

Please circle any of the following that apply to you:

Recent fever Diabetes Prostate Problem High Blood Pressure Menstrual Problems

Urinary Problems Stroke(date)_____ Currently Pregnant # of weeks____

Corticosteroid Use Abnormal Weight Gain/Loss Taking Birth Control Pills Pain at night

Marked Morning Pain/Stiffness Dizziness/Fainting Visual Disturbances Numbness in Groin/Buttocks

Pain Unrelieved by Position or Rest Cancer/Tumor_____

Osteoporosis Epilepsy/Seizures Surgeries_____

Family History_____ **Medications**_____ _____

I certify to the best of my knowledge; the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition. I understand that my chiropractor or a clinical peer employed by Insurance may need to contact my physical if my conditions need to be co-managed. Therefore, I give authorization to my chiropractor and/or Insurance to contact my physician, if necessary.

Patient Signature_____ **Date**_____