**PATIENT NAME:** ____________________ **DOB:** ____________

## MEDICAL INFORMATION AND HISTORY

**Height**________ **Weight**________

__ Recent Fever
__ Diabetes
__ High Blood Pressure
__ Heart Problems
__ Stroke (Date) ______
__ Corticosteroid Use
__ Dizziness/Fainting
__ Cancer/Tumor (Explain) ______________
__ Epilepsy/Seizure
__ Osteoporosis
__ Marked Morning Stiffness
__ Pain Unrelieved by Position or Rest
__ Pain at Night
__ Visual Disturbances
__ Headache or __ Migraine
__ TMJ/TMD
__ Fibromyalgia
__ Arthritis Type ____________
__ Other Health Problems (Explain) ________
______________________________

**Past Surgeries** (Type/Date)**:** ______________________________

**Have you ever been involved in a car accident or a serious fall** (Explain/Date)**:** ______________________________

**Current Medications/Supplements:** ______________________________

**Primary Care Physician:** ____________________ **Phone Number:** ____________

**Have you been previously treated for the conditon that you are here for today? YES | NO**

**If YES, what was the outcome/results** (Explain) ______________________________

**Additional Relevant Information:** ______________________________

## HEALTH INSURANCE INFORMATION (Please provide drivers license and insurance card.)

**Health Insurance Company:** ____________________ **Telephone Num.** ____________

**Address:** ______________________________

**Member Name** (as it appears on card)**:** ____________________ **Member DOB:** ________

**Member ID Number:** ____________________ **Relation to Policy Holder:** ____________

**Policy Holder Name:** ____________________ **Policy Holder DOB:** ________

I hereby authorize Dr. Douglas Nagel, DC to release any medical information necessary to ajudicate and process my insurance claims, and request payments of benefits to made directly to Dr. Douglas Nagel. Back 2 Life Chiropractic and Sports Medicine will submit fee for services rendered to my insurance company for payment. I understand that I am responsible for payment in full for any fees, coinsurance, and/or co-payments not paid by my insurance company.

**PATIENT** (OR GUARDIAN) **SIGNATURE:** ____________________ **DATE:** ________

PRINT NAME: ____________________