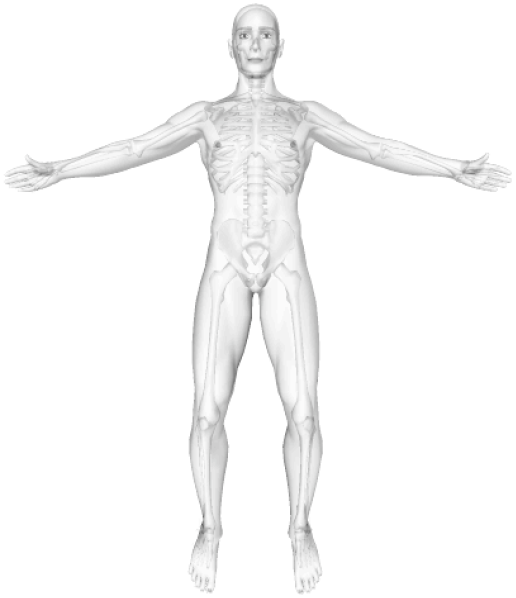
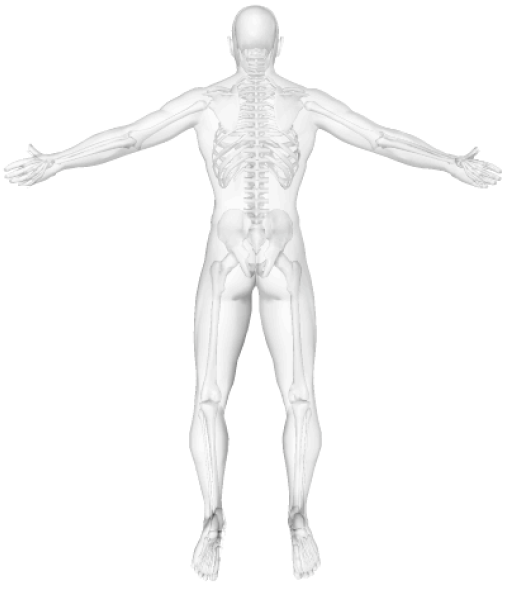
NORTHERN LAKES CHIROPRACTIC CLINIC, P.C.

Date_____
Name_____Age_____Birth Date_____Sex: M F
Address_____City_____State_____Zip_____
Home Phone_____Cell Phone_____ Social Security No. _____
Family Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated No. of Children _____
Your Occupation_____Employer _____
Employer's Address_____Telephone_____
Health Insurance Company _____
Insured's Name_____Insured's Date of Birth_____
Spouse (or parent/guardian)_____
Their Occupation_____ Employer _____
Employer's Address_____Telephone_____
Emergency Contact_____Telephone_____
Nearest Relative (not living with you) _____Telephone_____
Have you had chiropractic care before? ❑Yes ❑No Chiropractor's Name_____
For what problem?_____ Date of last chiropractic treatment_____
Have you been treated by a medical physician for any health condition in the last 6 months? ❑ Yes ❑ No
If yes, please explain_____
Who is your primary care physician?_____
Who referred you to us? _____
What is your complaint/symptom today?_____
What was the cause of your pain and when did it start?_____
_____
Is your complaint related to an on the job injury? ❑ Yes ❑ No Motor vehicle accident? ❑ Yes ❑ No
Have you had x-rays? ❑ Yes ❑ No MRI? ❑ Yes ❑ No Date and Location _____
Describe your major pain: ❑ CONSTANT ❑ COMES AND GOES ❑ SHARP ❑ DULL ❑ ACHE ❑ BURNING
Symptoms other than above _____
What activities aggravate your condition?_____
What activities lessen your condition?_____
Any home remedies?_____
Is this condition worse during certain times of the day? ❑ Yes ❑ No If yes, when?_____
Is this condition interfering with: ❑ Work ❑ Sleep ❑ Routine ❑ Other_____
Is this condition getting: ❑ Worse ❑ Better ❑ Staying the same?

✎ **Mark or circle the area of your symptoms on the drawing below and indicate if painful, numb, tingling, weak, etc.**





✔ PLEASE TURN OVER AND COMPLETE THE OTHER SIDE. ✎

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What other doctors have you seen for this?_____
Have you ever had: ❑ Surgery ❑ Fractures ❑ Car Accidents ❑ On the job injuries ❑ Trauma
Previous serious illness or hospitalization (please list and describe) _____
_____
Family history of: ❑ Heart Disease ❑ Cancer ❑ Stroke ❑ Diabetes ❑ Arthritis ❑ Back Problems ❑ Disc Problems
Other_____
List all medications you are taking_____
List any allergies_____
If you are female, are you possibly pregnant? ❑ Yes ❑ No Do you use birth control? ❑ Yes ❑ No
What would you like to improve through treatment? _____
_____
Have you had or do you now have any of the following symptoms? Please indicate each with a ✔.

_____Headaches	_____Stroke	_____Cancer
_____Neck Pain	_____Nervousness	_____Diabetes
_____Pain between shoulders	_____Irritability	_____Heart trouble
_____Lower back pain	_____Sleeping problems	_____Kidney trouble
_____Tension/stiffness	_____Weakness	_____Thyroid problems
_____Arm pain	_____Fatigue	_____Lung problems
_____Shoulder pain	_____Loss of memory	_____Shortness of breath
_____Hip pain	_____Depression	_____ Chest pain
_____Leg pain	_____Fainting	_____Breast disease
_____Foot pain	_____ Dizziness of loss of balance	_____Tuberculosis
_____Tingling or numbness in arms	_____Ulcers	_____Fever
_____Tingling or numbness in legs	_____Digestive problems	_____Prostate problems
_____Bursitis	_____Constipation	_____Night pain
_____Arthritis	_____Diarrhea	_____Loss of smell or taste
_____Osteoporosis (thin bones)	_____Light bothers eyes	_____Allergies
_____High blood pressure	_____Cold hands or feet	_____Sinus trouble
_____Ringing in ears	_____Cold or frequent sweating	_____Rheumatic fever

Health Habits: (please ✔)

Exercise:	❑ None	❑ Light	❑ Moderate	❑ Heavy	_____Times/week
Alcohol:	❑ None	❑ Light	❑ Moderate	❑ Heavy	_____Times/week
Vitamins:	❑ None	❑ Light	❑ Moderate	❑ Heavy	_____Times/week
Smoking:	❑ None	❑ Light	❑ Moderate	❑ Heavy	_____Packs/day
Coffee:	❑ None	❑ Light	❑ Moderate	❑ Heavy	_____Cups/day
Water:	❑ None	❑ Light	❑ Moderate	❑ Heavy	_____Glasses per day

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To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. **(PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMENT.) IN ORDER TO MONITOR YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT**. Thank You.

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature_____ Date_____

MEDICARE ASSIGNMENT/SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Northern Lakes Chiropractic Clinic, P.C. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents, any information needed to determine these benefits, or the benefits payable for related services.

Signature_____ Date_____