Panchur Chiropractic Wellness Centre

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Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City/State:_____ Zip:_____ Cell Phone: _____

SS#: _____ Work Phone: _____

Date of Birth: _____ Age:_____ Email: _____

Marital Status: M S W D Referred By: _____

Race/ Ethnicity ( )White/Caucasian ( )Black/African American ( )Asian ( )American Indian

( )Hispanic/Latino/Spanish Origin ( )Other:_____

Preferred Language ( )English ( )Spanish ( )Other:_____

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Emergency Contact Name: _____ Phone # _____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office: _____

Pain or Problem started on_____

What seemed to be the initial cause? _____

Pains are: ( )Sharp ( )Dull/Ache ( )Constant ( )Intermittent ( )Other_____

Does this pain shoot, radiate, or travel in your body? **Y / N** Where? _____

Are you experiencing numbness or tingling in any area of your body? **Y / N** Where? _____

Since it began, it is: ( )Same ( )Better ( )Worse

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with ( )Work ( )Sleep ( )Routine ( )Other:_____

Is this condition progressively getting worse? _____

Please circle your pain level: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse Possible Complaint/Pain)

Other Doctors seen for this condition_____

Have you ever been under Chiropractic Care? **Y / N** If so, Who/Date of Last Adjustment? _____

Have you ever received Acupuncture Care? **Y / N**

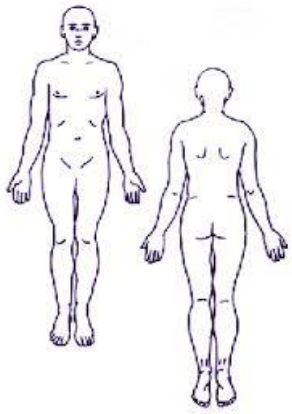
Any home remedies? _____

Are you under medical care for any condition? _____

Hobbies/Sports injuries? **Y / N** _____

Office Use Only: Height_____ Weight_____ BP (R or L) _____

Using the symbols below, mark on the pictures where you feel pain



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other	^ ^ ^

Have you ever had Surgery? **Y / N** Date:_____ Type:_____

Have you been in accidents/trauma? **Y / N** _____

Did/Do you smoke? ( )Never ( )Former ( )Current ( )Everyday ( )Some Days

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? **Y / N** If so, Where?_____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications, drugs or supplements are you taking? (please list) _____

_____

Allergies: Food, Medication or Environmental (include reactions):_____

_____

Do you exercise? **Y / N** If yes, type:_____

Sleeping Posture? ( )Side ( )Stomach ( )Back

Are you pregnant? **Y / N**

Family Physician: _____ (Note: May we send your health information to this provider **Y / N**)

What is your goal in our office? _____

Additional Information you want the Doctor to know: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Panchur Chiropractic Wellness Centre** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

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. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date