Name _____

Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

E-Mail for Monthly Updates _____ Age _____

How did you hear about us? Google Search □ Bing Search □ Yahoo Search □ Location □
Other □ (please list other source) _____
Birth Date _____ Marital: M S W D How Many Children? _____

Occupation _____ Employer _____

Name of Spouse _____ Occupation _____

Emergency Contact Name _____Phone _____

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of auto or other accident? _____

Days lost from work? _____ Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition: Yes _____ No _____ If yes, when and describe _____

_____

Date of last physical exam _____

List any operations you've had and the date/year: _____

Past/Current Serious illnesses and the date/year:_____

Have you suffered from:

Dizziness Y / N	Arthritis Y / N	Digestive Disorders Y / N
Backaches Y / N	Headaches Y / N	Nervousness Y / N
Heart Trouble Y / N	Numbness Y / N	Sinus Trouble Y / N
Diabetes Y / N	Asthma Y / N	Anemia Y / N
Tuberculosis Y / N	Neuritis Y / N	Rheumatic Fever Y / N
Cancer Y / N	Other:	

Other Doctors seen for this condition _____

Have you been treated for ANY health condition by a physician in the last year? Y / N

If Yes—Describe: _____

What medications are you taking (prescription/over-the-counter/vitamins) _____

_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I request Bayside Family Chiropractic to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

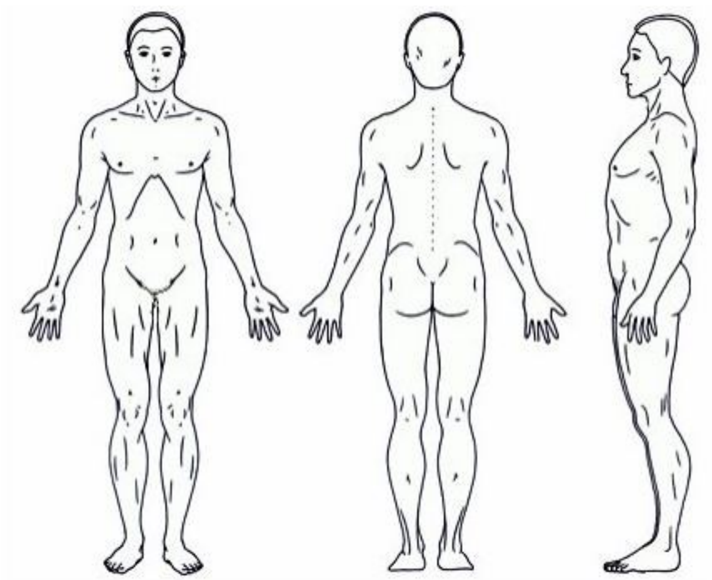
If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that **I am ultimately responsible for payment in full**. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Signature ___________________________ (If under 18)Guardians Signature ____________________________ Date ______

_ _

USE THIS CHART TO INDICATE PAIN AREA & TYPE

CHART KEY:
Numbness - - -
Dull Ache 000
Burning XXX
Sharp/Stabbing ///
Pins & Needles + + +
Other ^^^



1) What is your major complaint?

____

2) Is this a reoccurrence? When was the first time you noticed the problem? ____

How did it occur? ____

Has it become worse recently? ___________________________________ If yes, when? ________________________________

3) How frequent is the condition? ____

How long does it last? ____

4) Are there any other conditions or symptoms you have that may be RELATED to your major symptom? _____________________

____

Are there any other UNRELATED health problems? ____

5) Is there anything you can do which seems to provide relief? ____

6) What things seem to make the problem worse? ____

7) Have you had any broken bones? ___________ If yes, please list and give year/age: ___________________________________

8) List any major accidents you have had other than those that might be mentioned above ______________________________

____

9) To your knowledge, have you had any disease, major accidents, or injuries not indicated on this form either in the past or the present? ____________ If yes, please explain: ____

10) WOMEN ONLY: Are you pregnant or do you feel that there is any possibility you may be pregnant? ______________________

11) Extra Information you would like the Doctor to know:

____