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Today's Date:_____

Patient Information:

First Name:_____ Last Name:_____

DOB: ___/___/_____ Gender: ( ) Male ( ) Female

Address:_____

City/State/Zip _____

PHONE# _____

Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Is this patient currently taking any medications?_____

Medication Name Dosage and Frequency (i.e. 5mg once a day, etc.)(Please include regularly used over the counter medications) _____
*If more than 3 medications, please continue list on back of page

Does this patient have any medication allergies?_____

Medication Name, Reaction Onset Date, Additional Comments_____
_____

What is the name of this patient's medical doctor? _____

Parent/Guardian information: (If anything is the same as above write S where applicable)

Name / Names _____

PHONE# _____ Alternative Phone: _____

Address:_____

City/State/Zip _____

Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Your Employer::_____ Occupation: _____
Employer's Address: _____

OF CHILDREN _____ MARITAL STATUS S M D W

SPOUSES NAME _____

PERSON RESPONSIBLE FOR PAYMENT _____

HOW WERE YOU REFERRED TO OUR OFFICE? Ex: FRIEND'S NAME _____

Has the patient EVER HAD CHIROPRACTIC CARE BEFORE? _____

IF YES, WHEN?_____

IS THIS INJURY/ILLNESS WORK-RELATED? _____

HAS the incident been reported to an EMPLOYER? _____

IS THIS INJURY/ILLNESS RELATED TO AN AUTOMOBILE ACCIDENT? _____

(IF YES, PLEASE GIVE FOLLOWING INFORMATION)

AUTO INSURANCE CO. _____ POLICY# _____ CLAIM# _____

PHONE#_____

ADDRESS _____ AGENT'S NAME

_____

NAME OF ATTORNEY _____ ADDRESS _____

PHONE#_____

DO YOU HAVE ANY TYPE OF HEALTH INSURANCE? _____

POLICY/GROUP# _____

INSURANCE COMPANY _____ ADDRESS _____

INSURED'S NAME _____ RELATION _____

SOCIAL SECURITY#_____ DRIVER'S LICENSE#_____

ARE YOU COVERED UNDER ANY OTHER GROUP OR INDIVIDUAL HEALTH POLICY THROUGH YOURSELF OR SPOUSE? _____

INSURANCE COMPANY _____ ADDRESS

_____

POLICY/GROUP# _____ INSURED SS# _____

WHAT IS THE PATIENT'S MAJOR COMPLAINT?

_____

IS THIS CONDITION DUE TO AN A) AUTO ACCIDENT B) WORK INJURY C) OTHER ACCIDENT D) UNKNOWN CAUSE E) ILLNESS

ARE THE SYMPTOMS: A) IMPROVING B) GETTING WORSE C) ABOUT THE SAME D) INTERMITTENT (COME AND GO)

DATE SYMPTOMS APPEARED _____

CIRCLE ANY ACTIVITIES WHICH AGGRAVATE THE CONDITON:

A) STANDING B) WALKING C) SITTING D) LYING E) BENDING F) LIFTING G) TWISTING H) COUGHING I) OTHER_____

HAVE YOU HAD THESE SYMPTOMS BEFORE? _____ IF SO, WHEN? _____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? A) M.D. B) CHIROPRACTOR C) OSTEOPATH D) ACUPUNCTURIST E) DENTIST F) PODIATRIST

DR.'S NAME _____ DATE CONSULTED _____

DIAGNOSIS_____

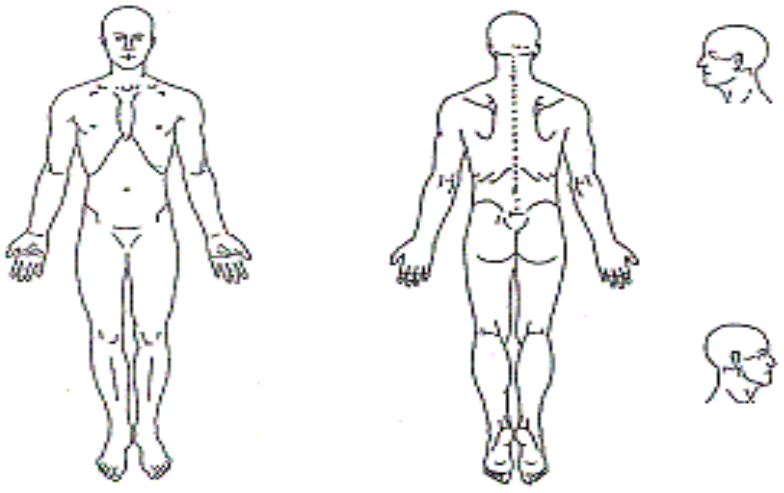
HAS THE PATIENT EVER HAD ANY SURGERIES?

_____

DRUGS YOU NOW TAKE: ___ASPRIN ___PAIN KILLERS ___ TRANQUILIZERS ___INSULIN ___BIRTH CONTROL PILLS___ OTHER (PLEASE LIST)

IF THE PATIENT IS IN PAIN, PLEASE MARK THE EXACT LOCATION OF THE PAIN ON THE DIAGRAM BELOW. ALSO DESCRIBE THE TYPE AND FREQUENCY OF THE PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN. FOR EXAMPLE, DULL, SHARP, CONSTANT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

COMPLETE THESE DIAGRAMS



Would you like a copy of the patient's report every visit? _____

PATIENT'S GUARDIAN'S SIGNATURE:

_____Date:_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractor named above.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name (Patient full Name) _____

Signature of Patient's Guardian:_____Date: _____

Patient's Guardian name printed: _____

I, _____ authorize 4:40 Chiropractic to release any information pertinent to my case to business associates for purposes of carrying out billing and back office duties.

Patient's Name (Patient full Name) _____

Signature of Patient's Guardian:_____Date: _____

Patient's Guardian name printed: _____