PATIENT INFORMATION

Nashville SPINE • SPORT • FAMILY
Chiropractic • Massage • Therapy • Nutrition

Date: _____ / _____ / _____ File #: _____

Name: _____ Preferred Name: _____

SS#: _____ DOB: _____ / _____ / _____ Age: _____ Male Female

Address: _____ City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email Address: _____ Referred by: _____

Status: Minor Single Married Other: _____ Spouse's Name: _____

Have children? Yes No If so, how many? _____

Have you seen a chiropractor before? Yes No Clinic/Doctor's Name: _____

Who is your Medical Doctor? _____ Phone: _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Employment Information

Employer Name: _____ Occupation: _____ How long? _____

Address: _____ City, State, Zip: _____

Primary Insurance

Insurance Co.: _____

Group #: _____

Subscriber ID: _____

Address: _____

_____

Insured's Name: _____

Insured's Employer: _____

Insured's SS#: _____

Relation: _____ DOB: _____

Secondary Insurance

Insurance Co.: _____

Group #: _____

Subscriber ID: _____

Address: _____

_____

Insured's Name: _____

Insured's Employer: _____

Insured's SS#: _____

Relation: _____ DOB: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Person ultimately responsible for account (if same as patient, just leave blank)

Name: _____ Relation: _____ DOB: _____

Billing Address: _____

Driver's License #: _____ Phone: _____

MEDICAL HISTORY

Reason for today's visit: _____ Emergency _____ New injury _____ Old injury _____ Chronic pain _____ Wellness

Are you in pain? _____ Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Where did your injury occur? _____ Work _____ Sports/Play _____ Auto Accident _____ Routine/Household Activity

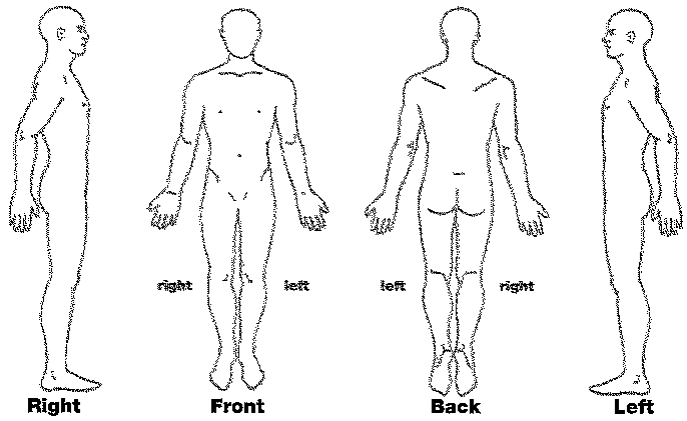
When did your condition/accident occur? _____ Where? _____

Please explain what happened: _____

Is condition interfering with: _____ Work _____ Sleep or _____ Daily routine? If so, how: _____

Has this or something similar happened in the past? Yes No If Yes, explain: _____

Using the body chart below, please circle all affected areas.



Y N Heart Attack/Stroke
Y N Fainting/Seizures/Epilepsy
Y N Psychiatric Problems
Y N Heart Surgery/Pacemaker
Y N Artificial Valves
Y N Severe/Frequent Headaches
Y N Rheumatic Fever
Y N Hepatitis

Are you taking any of the following medications?

Nerve pills Painkiller (i.e. Aspirin) Muscle Relaxers
Blood thinners Tranquilizers Insulin Other: _____

Please circle yes (Y) or no (N) on the following:

Y N Difficulty Breathing
Y N Chemotherapy
Y N Heart Murmur
Y N Shingles
Y N Venereal Disease
Y N HIV/AIDS/ARC
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N Frequent Neck Pain
Y N Anemia/Diabetes
Y N Mitral Valve Prolapse
Y N Cancer
Y N Lower Back Pain
Y N Kidney Problems
Y N High/Low Blood Pressure
Y N Artificial Bones/Joints
Y N Tuberculosis
Y N Emphysema/Asthma
Y N Arthritis
Y N Glaucoma
Y N Ulcers/Colitis
Y N Sinus Problems

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

_____

List any serious accidents with dates: _____

Family health history: _____

Take supplements/vitamins? No Yes Do you exercise? No Yes If yes, how often? _____

Do you smoke? No Yes How often? _____ For how long? _____

Do you drink alcohol? No Yes If so, how many drinks per week? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting? No Yes Since: _____

For women only: Are you on birth control? No Yes Are you nursing? No Yes

Are you pregnant? No Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges, and any other expenses incurred in collecting on your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: _____ DATE: _____