CarePlus CHIROPRACTIC

Welcome to our practice and thank you for selecting us for your chiropractic needs.

Complete all questions on both sides of this form so that we may proceed with your initial exam. We will perform a computerized analysis of the area of complaint, followed by a physical exam and X-rays by the doctor. Your first visit with us will take approximately 45-60 minutes. If you are in extreme discomfort, we will provide you with emergency procedures, otherwise, there are usually no treatments rendered on the examination visit. Your next visit will include a detailed explanation of your condition and our recommended treatment program, assuming you fall within the scope of chiropractic care. Provide us with your Driver's License and Insurance card. **PLEASE PRINT CLEARLY AND LEGIBLY. Thank you.**

INTRODUCTION

Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female Social Security No. _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed You became aware of this office from _____

Case Type ☐ Cash/No Insurance Coverage ☐ Major Medical Insurance ☐ Auto Accident ☐ Work Injury

Employment ☐ Part Time ☐ Full Time ☐ Unemployed Occupation _____

Employer _____ Address _____

MAJOR MEDICAL INSURANCE INFORMATION

Policy Holder _____ Relationship _____ Policy Holder's SS# _____

Insurance Company _____ Policy # _____ Group # _____

Insurance Address _____ City _____ State _____ Zip _____

AUTO ACCIDENT INFORMATION

Date of Injury ____/____/____ Time of Injury _____ AM/PM Street and Town _____

Hospital and treatments _____

Describe the accident (Your car is Vehicle #1; Other car is Vehicle #2) _____

_____

Describe your injury _____

_____

Where did you sit? _____ Did you wear a seat belt? _____ Was the airbag deployed? _____

Other passengers _____ Did you stop working? _____ Dates _____

Auto Insurance _____Policy Holder _____ Case/File # _____

Insurance Address _____ City _____ State _____ Zip _____

WORK INJURY INFORMATION

Date of Injury ____/____/____ Time of Injury _____ AM/PM Street and Town _____

Describe your injury _____

_____ Did you stop working? _____ Dates _____

Insurance Company _____ Carrier Case # _____ WCB # _____

MY PROBLEM

Name _____ Date _____ Height _____' _____" Weight _____ lbs.

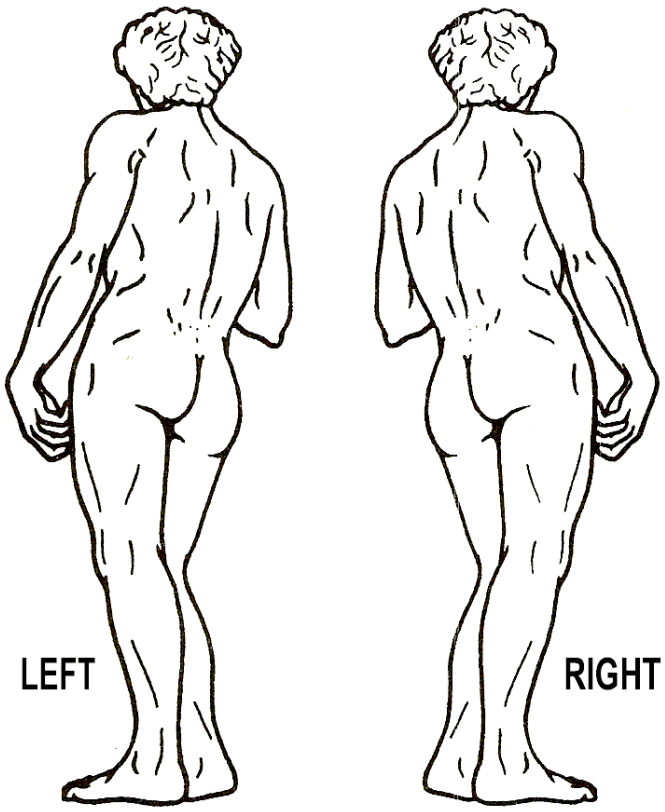
The pain developed ☐ Suddenly ☐ Gradually Since _____

The pain feels ☐ Sharp ☐ Shooting ☐ Dull ☐ Achy ☐Burning ☐ Tingly

Describe location(s) involved _____

What worsens the problem? _____

Circle the areas of complaint on the diagram below.
Place a number between 1 and 5 for the intensity of the pain;
1 for minimal pain and 5 for severe pain



PREVIOUS/PRESENT TREATMENTS FOR THIS CONDITION

Doctor/Facility _____ Phone _____

Results _____

List medications you are presently taking.

Pain Killers _____

Anti-inflammatory _____

Muscle relaxants _____

The information provided above is true. I authorize release of my medical information to CarePlus Chiropractic, P.C. regarding my case.

Signature _____ Date _____

Family History:

☐ Chronic back problems
☐ Chronic headaches
☐ Diabetes
☐ Rheumatoid Arthritis
☐ Lung problems
☐ High Blood Pressure
☐ Heart Problems

Your Health History:

Past	Present	
☐	☐	Headaches
☐	☐	Rheumatoid Arthritis
☐	☐	Fatigue
☐	☐	Visual Disturbances
☐	☐	Dizziness
☐	☐	Convulsions
☐	☐	Cancer
☐	☐	Tumor
☐	☐	High Blood Pressure
☐	☐	Chest Pains
☐	☐	Epilepsy
☐	☐	Stroke
☐	☐	Angina Pectoris
☐	☐	Aortic Aneurysm
☐	☐	Kidney Disorder
☐	☐	Painful Urination
☐	☐	Prostate Problems
☐	☐	Ulcers
☐	☐	Colitis
☐	☐	Diabetes
☐	☐	Liver Disorder
☐	☐	Emphysema
☐	☐	Asthma
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	HIV/AIDS