

Leander

Chiropractic

Center

Patient Information	Insurance
Today's Date: ____/____/____ Name _____ Address _____ _____ <div style="display: flex; justify-content: space-between;"> City _____ State _____ Zip _____ </div> Home Telephone _____ Cell/Work Phone _____ Best time and place to reach you _____ Patient's Birthday _____ Employer _____ Work Telephone _____ Occupation _____ (If patient is a minor, please write in parent's information below): Spouse's Name _____ Spouse's Birthday _____ Occupation _____ Spouse's Employer _____ Whom may we thank for referring you to our office? _____	Name of Insured _____ Relationship to Patient _____ Insurance Co. _____ ID# _____ Date of Birth _____ Group# _____ Is patient covered by additional insurance? Y N ASSIGNMENT AND RELEASE I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Blatchley D.C. all insurance benefits, if any, for service rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. _____ Responsible Party Signature _____ Relationship Date

Patient's Condition

Reason for visit _____

How long ago did your symptoms first appear? _____

What were you doing when they appeared? _____

Is this condition getting progressively worse? **Yes** **No**

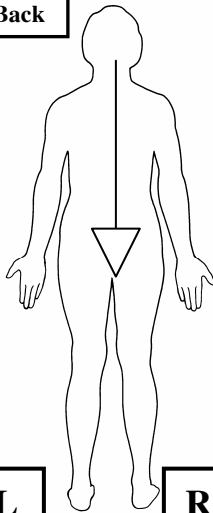
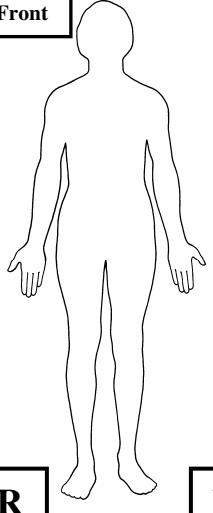
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Is it constant or does it come and go? _____

Place an X next to the left of the symptoms that you have had in the past 3 months:

	Headaches		Numbness in legs Rt. Lt.
	Neck Pain		Numbness in Arms Rt. Lt.
	Mid Back Pain		Numbness in Hands Rt. Lt.
	Low-back Pain		Difficulty Sleeping
	Dizziness		Pins & Needles in Arms Rt. Lt.
	Chest/Sternum Pn.		Pins & Needles in Legs Rt. Lt.
	Nausea		Leg Pain Rt. Lt.
	Nervousness		Shoulder Pain Rt. Lt.
	Fatigue		Foot/Ankle Pain Rt. Lt.
	Loss of Balance		General Tension
	Jaw Pain		Depression
	Buzzing in Ears		Stomach Upset
	Loss of Memory		Shortness of Breath
Write in any other: _____			

Color the chart where your symptoms are bothering you the most.

Back	Front
	
L	R R
L	R R

Past Health History

What treatment have you already received for your condition? Circle all that apply.

Medications Surgery Physical Therapy Chiropractic Services None Other _____

In case we need to refer you in the future, please write the name of your medical doctor _____

Place an X in the box to the left of each of the conditions listed below that you have been diagnosed with in the past:

<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Bulging/Herniated Disk	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Pinched Nerve
<input type="checkbox"/>	Bleeding Disorders, Poor Clotting	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	PMS
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hypotension	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Prosthesis:
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Stroke

Is there a family history of any of the following: Write in their relationship to you, ex: mom, dad etc.

<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Numbness in legs
<input type="checkbox"/>	Mid-back Pain	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Numbness in Arms
<input type="checkbox"/>	Low-back Pain	<input type="checkbox"/>	Loss of Balance	<input type="checkbox"/>	Numbness in Hands
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	Difficulty Sleeping
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Buzzing in Ears	<input type="checkbox"/>	Pins & Needles in Arms
<input type="checkbox"/>	Chest/Sternum Pn.	<input type="checkbox"/>	General Tension	<input type="checkbox"/>	Pins & Needles in Legs
<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	Foot/Ankle Pain	<input type="checkbox"/>	Leg Pain

Are you Pregnant? No Yes Due Date _____

Please list any of the following:

Description

Dates

Falls	_____	_____
Head Injuries	_____	_____
Auto Accidents	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Surgeries	_____	_____
Surgeries	_____	_____

List any condition in which you take medications (please don't list the drugs because they can become numerous):

Place an X to the left of any that apply to you.

Exercise		Work Activity		Sleeping Position		Nutrition	
<input type="checkbox"/>	None	<input type="checkbox"/>	Sitting longer than 20 minutes	<input type="checkbox"/>	Back	<input type="checkbox"/>	Vitamins
<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Standing for longer than 1 hour	<input type="checkbox"/>	Sides	<input type="checkbox"/>	Herbs
<input type="checkbox"/>	Heavy	<input type="checkbox"/>	Light Labor	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	Minerals
<input type="checkbox"/>		<input type="checkbox"/>	Heavy Labor	<input type="checkbox"/>	All Three	<input type="checkbox"/>	None