Today's Date: _____

Information for Patient Care

Patient: _____ DOB: _____ Age: _____ Sex: (M / F)
Social Security #_____ Race: _____ Ethnicity: _____
Current Address: _____ City: _____ State: _____ Zip: _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
E-mail:_____ Would you like to receive e-news letters? (Y / N)
Employer _____ Occupation _____ Years Employed _____
Employer Address _____ City _____ State _____ Zip _____
Marital Status: S M W D Number of Children: _____
Name of Spouse: _____ Spouse's DOB: _____
Spouse's employer: _____ Spouse's cell: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about us? _____

Insurance Information If Patient is not Primary Card Holder

Insured's Name: _____ ID#: _____ Insured's Sex: (M / F)
Insured's Birth date: _____ Relationship to Insured: (Spouse / Child / Other)
Insured's Employer: _____ Insured's Social Security # _____
Please check any and all insurance coverage that may be applicable in this case:
( ) Major Medical ( ) Worker's Compensation ( ) Medicaid
( ) Medicare ( ) Auto Accident ( ) Medical Savings Account & Flex Plans
( ) Other

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable**. A $25.00 fee will be charged for NO SHOW and LATE CANCELLED appointments.**

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Notice to our new patients: Full payment of co-payment or services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Patient's Signature:_____ Date: _____
Parent or Guardian Signature Authorizing Care: _____ Date: _____

Health Inventory

Major Complaint Today:_____
Is this the result of an accident? ( ) auto ( ) work related ( ) at home ( ) other
Have you ever been in an accident? ( ) yes ( ) no
*If you have no symptoms or complaints today and are here for wellness services, please check here: ( )
How long have you had this condition? _____What have you done for it?_____
What aggravates this condition? _____
Have you been treated for any health conditions in the past year? Yes _____ No_____
If yes, please describe _____

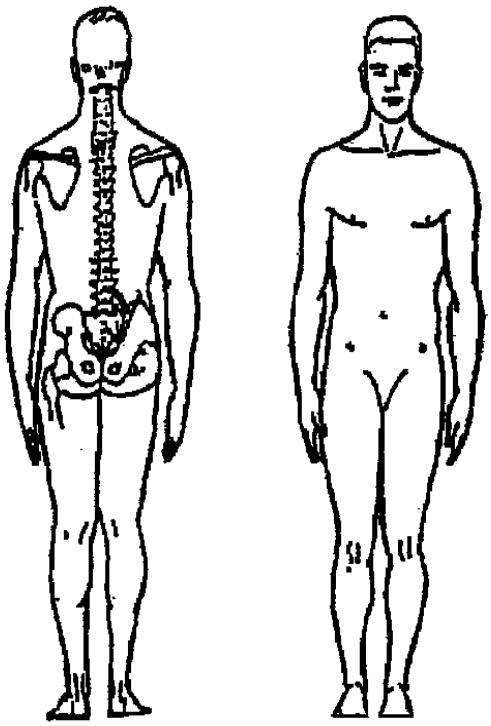
Have you had any previous surgeries or illnesses?_____

Do we have your permission to discuss your condition? (Yes / No)
If yes, with whom?_____ Relationship _____
Primary Care Doctor: _____
May we share your treatment at Inline Healing with your Primary Care Doctor? _____
Have you had any prior Chiropractic Care? _____ If so, what were you being treated for?_____
What medications are you currently taking? _____
If any, what are you taking the medications for?_____
Are you or is there a possibility you are pregnant?_____

Have You Ever Suffered From:

__ Allergy	__ Low Back Pain	__ Nausea
__ Dizziness	__ Neck Pain or stiffness	__ Asthma
__ Fatigue	__ Sciatica	__ Ear Noises
__ Headaches	__ Swollen Joints	__ Bruise easily
__ Loss of Sleep	__ Spinal curvatures	__ High Blood Pressure
__ Nervousness/Depression	__ Difficult digestion	__ Low Blood Pressure
__ Poor Circulation	__ Chest Pain	__ Difficult breathing
__ Swelling of ankles	__ Frequent Urination	__ Kidney infection or stone
__ Cancer	__ Cramps or backache	

Tingling or numbness in: Shoulder ___ Arms ___ Elbows ___ Hands ___ Hips ___ Legs ___ Knees ___ Feet___



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram and check the type of pain and frequency of your pain.

_____ Pain	_____ Numbness
_____ Spasm	_____ Sharp
_____ Dull	_____ Tenderness
_____ Constant	_____ Intermediate
_____ Radiates	

Does the pain increase or decrease when:

Sitting	( ) decreases	( ) increases
Standing	( ) decreases	( ) increases
Walking	( ) decreases	( ) increases
Running	( ) decreases	( ) increases
Stretching	( ) decreases	( ) increases

Pain Index: Circle One

Least 1 2 3 4 5 6 7 8 9 10 Worst

How would you describe your overall health? ( ) Good ( ) Fair ( ) Poor
Do you drink alcoholic beverages? ( ) Yes ( ) No If so, ( ) daily ( ) weekly ( ) monthly
Do you use any tobacco products? ( ) Yes ( ) No If so, packs per day: _____
Do you consume caffeine products? ( ) Yes ( ) No If so, how much per day: _____
Do you exercise? ( ) Yes ( ) No If so, frequency and type of exercise:_____
What percentage of your time during the day do you spend: Standing _____ Lifting _____ Sitting_____
Bending _____Working at a computer _____