CONFIDENTIAL INFORMATION FOR YOUR FILE

Dr. ____________
File # ____________

Name ____________ Date ____________ X-ray # ____________
Address ____________ City ____________ State ____________ Zip ____________
Telephone ____________ Social Security No. ____________
Age ________ Birthdate ____________ Sex ________ Marriage Status: M S W D No. Children ________
Occupation ____________ Employer ____________ Yrs. Employed ________
Employer's Address ____________ Work Phone ____________ Bank ____________
Spouse's Name ____________ Occupation ____________ Employer ____________
Person responsible for this account ____________ Referred by ____________

INSURANCE INFORMATION:

Are you covered by Medicare? Yes ☐ No ☐ Medi-Cal? Yes ☐ No ☐ County ____________
Do you have any group, union or personal health and accident insurance? Yes ☐ No ☐
Name of Insurance Company ____________ Claim No. ____________
Address ____________ Agent ____________
Is your condition due to an accident or illness ____________
Did your accident occur while at work? Yes ☐ No ☐ When ____________
Were you involved in an automobile accident Yes ☐ No ☐ When ____________
Cash payment ____________ Other ____________
What is your major complaint? ____________

Other complaints ____________
How long have you had this condition? ____________ Have you had this or similar conditions in the past? ____________
What activities aggravate your condition? ____________
Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐
Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other ____________
How long has it been since you really felt good? ____________
Other doctors who treated this condition ____________

List surgical operations and years: ____________

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers
☐ Insulin ☐ Birth control pills ☐ Others ____________
Dental visits: ☐ Every 6 months ☐ Yearly ☐ Toothache or "emergency" only ☐ Complete dentures
Age of mattress ____________ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? ____________
Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports
Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never
Describe ____________
Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None
Describe ____________
Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? ____________
Have others in your family had such disorders? ☐ Yes ☐ No When? ____________

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ____________ SS # ____________ Date: ____________

Guardian or Spouse's
Signature Authorizing Care: ____________ Date: ____________

(Fill out other side if Job or Automobile Injury)

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SAMPLE

JOB OR AUTOMOBILE INJURY INFORMATION

JOB INJURY INFORMATION: Date ______ Time ______ Injury reported to employer ______
Description of accident ______

AUTO ACCIDENT INFORMATION: Date ______ Time ______ Police report made ______
Location ______
Were you struck from: Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Were you: Driver ☐ Passenger ☐
Description of Accident: ______

Were you injured ______ How ______
Where ______
Were you unconscious ______ Fractures ______ Cuts ______ Abrasions ______ Bruises ______
Patient taken to ______ Hospital for ______ treatment.
Confined to hospital for ______ Days Hours. Name of hospital doctor ______
What are your present complaints: ______

What treatments have you received ______

OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ DDS ☐
Doctor's name ______ Diagnosis ______
X-rays ______ Urinalysis ______ Blood Tests ______ Other ______
Treatment: Pills ______ Shots ______ Traction ______ Physiotherapy ______
Results ______ Length of time under his care ______ Other ______
Have you had any problems as the result of the injury ______

Were you off work ______ If so, how long ______
Have you returned to your same job ______ If not, why ______

HISTORY OF PRIOR INJURY, ILLNESS OR SURGERY: ______

Name of other party ______ Address ______
City ______ State ______ Phone ______
Their insurance company ______ Insurange Agent ______

ATTORNEY: Name ______ Address ______ Phone ______
Litigation: Yes ☐ No ☐ Maybe ☐ Comment ______

EXAMINATION: Date ______ Time ______ Dr. ______
Attitude ______ Posture ______ Perception ______
B.P. ______ Pulse ______ Resp. ______ Ht. ______ Wt. ______ Temperature ______

Structures Examined:
E. E. N. T., Teeth, Lungs, Heart, Lymphatics, Vessels, Joints, Muscles, Skin, Glands, Abdomen, Spine, Nerves, Rectum, Pelvis, G. U., Extremities.

Functions Tested:
Nerve, Muscle, glands, joints, systems.

Aberrations Noted:
(Chart each, showing related SUBJECTIVE SIGNS (SS), and OBJECTIVE SIGNS (OS) WITH THEIR METHOD OF DETECTION (DM). Include x-ray, instrumentation, laboratory, physical exam, etc.)

CONCLUSIONS: Diagnosis, etiology, prognosis for disabioity and/or recovery.

TREATMENT:

SAMPLE