

NEW PATIENT INFORMATION

REFERRED BY _____

NAME _____ Age: _____ Birthdate _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____ CELL# _____ SS # _____

E-MAIL _____ RELATIVE'S PHONE #: _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE _____

INSURED'S NAME _____ INSURED'S BIRTHDATE _____

INSURED'S ID # _____ RELATIONSHIP _____

GROUP # _____ INSURED'S EMPLOYER _____

INFORMED CONSENT FOR CARE: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Wasserman. I will have the opportunity to discuss with Dr. Wasserman and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I have read, or have had read to me, the above consent. I will have an opportunity to ask questions about its content, **and by signing below I agree to the above-named procedures.** I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) or which I seek treatment here at this office.

I ALSO GIVE MY FULL AND COMPLETE PERMISSION FOR THIS MEDICAL GROUP TO TREAT MYSELF OR MY MINOR CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY, AND **ASSIGN ALL MY PAYMENTS DUE TO THE DOCTOR.** I HEREBY AUTHORIZE THE GROUP TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT REQUIRED FOR THE PURPOSE OF BILLING. A PHOTOCOPY OF THIS ASSIGNMENT WILL BE AS VALID AS THE ORIGINAL.

THIS COMPLAINT OF _____ WAS **NOT** CAUSED BY AN AUTOMOBILE ACCIDENT, RELATED TO EMPLOYMENT, OR OCCUR ON COMMERCIAL PROPERTY.

SIGNATURE _____ DATE _____

Initial Symptom History

Please state your primary complaint of why you are here today: _____

What caused this and how long have you had it: _____

Have you had this condition in the past? _____

Please put a check that applies to your present condition:

Frequency: ___rare ___occasional ___frequent ___constant

Symptoms: ___pain ___stiffness ___spasms

Intensity: 0 (none)- 10 (severe) = ___neck ___mid ___low back ___extremity

Quality: ___sharp ___dull ___stabbing

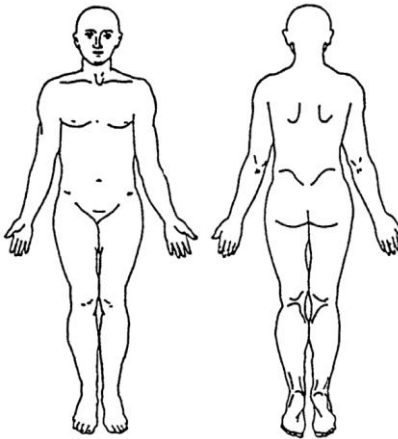
Assoc. Symptoms: ___weakness ___limited ranges of motion

radiating pain into _____ numb/tingling of _____

Aggravated by prolonged: ___sitting ___standing ___walking ___lying down ___driving

Relieved by: ___rest ___movement ___stretching ___Rx ___ice ___heat

Please mark the areas where your current complaints are located:



Signature _____ Date _____

INITIAL HEALTH HISTORY

Allergies: _____

Medications/Supplements _____

Cholesterol Lowering Drugs: _____

Surgeries/Hospitalizations: _____

Pace Maker/Metal /Breast Implants _____

Cancer: _____

Diabetes: _____

Heart Disease: _____

Stomach/Colon: _____

Etc. _____

Spinal Injuries/Accidents: _____

Previous Chiropractic Care: _____

Last Menstrual Period: _____ PREGNANT? () YES () NO

Previous MRI, CT Scans; X-Rays: _____

Exercise/Sports Activities: _____ times per week: 1 2 3 4 5 6 7

Average Daily Emotional Stress Level: ()very high ()high ()medium ()minimal

Patient Signature _____ **Date** _____

Comments:

VAS – Visual Analog Scale

Patient: _____ Date: _____

1. **WHERE IS YOUR PAIN LOCATED?** head neck mid back low back _____

2. **WHAT IS PAIN LEVEL RIGHT NOW?** Please circle

0-10 Numeric Pain Rating Scale



3. **WHAT IS YOUR PAIN AT ITS WORST?** Please circle

0-10 Numeric Pain Rating Scale



4. **WHAT IS YOUR PAIN LEVEL AT ITS BEST?** Please circle

0-10 Numeric Pain Rating Scale



5. **WHAT WAS YOUR INITIAL PAIN LEVEL BEFORE BEING TREATED AT THIS OFFICE?** Please circle

0-10 Numeric Pain Rating Scale



PATIENT SIGNATURE: _____ DATE: _____

SYMPTOM SURVEY

DATE: _____

Please circle the below injuries you directly suffered from your accident and that you are now feeling since the accident:

1. Headaches
2. Neck pain
3. Middle back pain
4. Low back pain
5. Shoulder pain, right, left
6. Arm pain, right, left
7. Leg pain, right, left
8. Numbness/tingling of hand, right, left
9. Numbness/tingling of leg, foot, right, left
10. Other_____

COMMENTS:

PATIENT
SIGNATURE_____