

# WHAT'S NEW

## 1

### ABOUT YOU

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ File #: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
LAST FIRST MI

Mailing Address: \_\_\_\_\_  
(  UNCHANGED )

CITY STATE ZIP

Home phone: ( \_\_\_\_\_ ) \_\_\_\_\_

( \_\_\_\_\_ ) OFFICE PHONE EXT. ( \_\_\_\_\_ ) CELL PHONE

E-mail Address: \_\_\_\_\_

**Employer:** \_\_\_\_\_  
(  UNCHANGED )

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

**Marital Status:** \_\_\_\_\_  
(  UNCHANGED )

Spouse's Name: \_\_\_\_\_

## 2

### INSURANCE INFO

Has any of your Insurance Information changed?  No  Yes  
If your insurance info has **not** changed, please continue on to block 3.

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

\_\_\_\_\_  
Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please provide any **new** Primary/Secondary Ins. cards with this form.

## 3

### MEDICAL INFO

What Medications are you taking? (please include over-the-counter drugs) \_\_\_\_\_

Please list any **new** allergies, diseases, medical conditions, or procedures; include dates when possible: \_\_\_\_\_

In event of an emergency, whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell #: ( \_\_\_\_\_ ) \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# BODY CHART

## REASON FOR VISIT

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ File #: \_\_\_\_\_

What is your current weight: \_\_\_\_\_ lbs., and height, \_\_\_\_\_ Ft. \_\_\_\_\_ In..

Reason for visit:  Work Accident  Sports Injury  Car Accident  Trauma/Injury  Chronic Pain  Routine Adjustment

Explain what happened: \_\_\_\_\_

When did condition begin? \_\_\_/\_\_\_/\_\_\_ Is this condition getting worse?  Yes  No  Constant  Comes & goes

Does it interfere with your:  Work  Sleep  Daily Routine Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

## SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness  
Symbol → NNNN

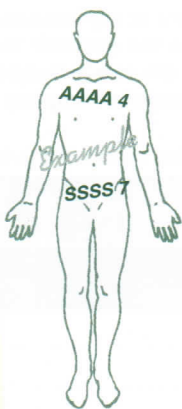
Pins & Needles  
PPPP

Burning  
BBBB

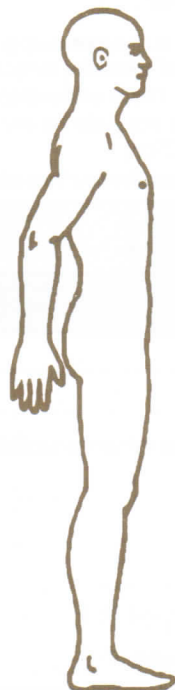
Aching  
AAAA

Stabbing  
SSSS

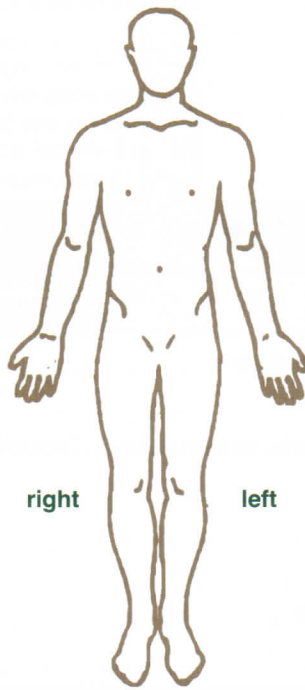
○ Circle any area of pain not represented by a symbol.



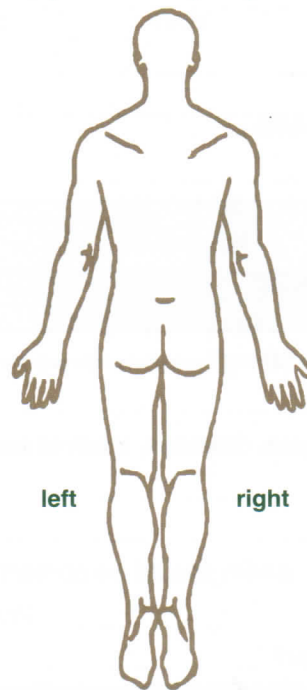
Example



Right



Front



Back



Left

## DOCTOR'S NOTES

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