

**PATIENT INFORMATION** DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zipcode

HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: Married Single Divorced Widowed

EMERGENCY CONTACT INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Telephone Number

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE COMPANY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If person responsible is someone other than the patient, we need the name and birthdate for billing.**

RESPONSIBLE PERSON (SPOUSE/PARENT/ OTHER) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE \_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Gordon L. Roberts, DC, all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I, hereby, authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature to all insurance admissions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Date

**HEALTH INFORMATION**

HEIGHT \_\_\_\_ FEET \_\_\_\_\_INCHES WEIGHT\_\_\_\_\_\_\_\_\_\_ LBS.

ARE YOU TAKING ANY MEDICATIONS? \_\_\_YES \_\_\_NO VITAMINS/HERBAL SUPPLEMENTS \_\_\_YES \_\_\_NO

If yes, please list medications/supplements (be specific) you are currently taking along with dosage.

If you have a medication list, we will be happy to make a copy of it for you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_ YES \_\_\_NO OTHER ALLERGIES (other than medications)

If yes, please list.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ YES \_\_\_\_\_\_NO HAVE YOU EVER SMOKED? \_\_\_\_\_\_ YES \_\_\_\_\_\_\_ NO

If current tobacco user, please complete the following:

WHAT TYPE OF TOBACCO? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW MUCH/HOW OFTEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

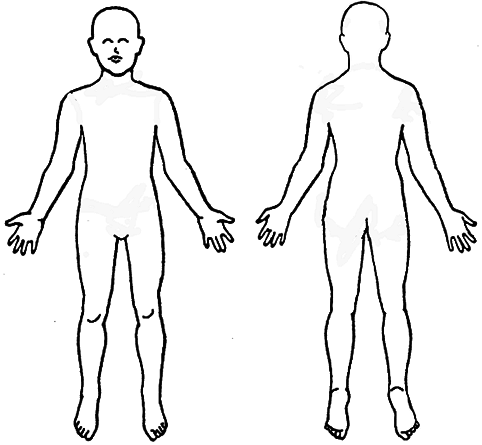
HAVE YOU TRIED TO QUIT? \_\_\_\_Yes \_\_\_\_ No WHAT METHOD DID YOU USE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEMOGRAPHICS**

Ethnicity: \_\_\_\_ Non-Hispanic \_\_\_\_ Hispanic

Preferred language: \_\_\_\_English \_\_\_\_ Spanish \_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_ White/Caucasian \_\_\_\_\_African American \_\_\_\_ Native American \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONDITION**

Reason for Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the condition getting worse? Yes No Unknown Rate the severity of the pain on a scale of 1 (least pain) to 10 (severe pain) \_\_\_\_

Type of pain: Sharp Dull Aching Burning Throbbing Numbness  Shooting Tingling Cramps Stiffness Swelling Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the pain  constant comes and goes

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down Mark an X on the picture where you have pain

**ACCIDENT INFORMATION**

Is condition due to an accident? YesNo Date \_\_\_\_\_\_ Type of accident Auto WorkHome Other

To whom have you made a report of your accident? Auto Insurance Employer Worker’s Comp.

**HEALTH HISTORY**

What treatment have you already received for your condition?  Medications  Surgery Physical Therapy Chiropractic Services None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Address of other doctor(s) who have treated you for your condition ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spinal X-Ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place a check mark on “Yes” or ‘No” to indicate if you have had any of the following:

AIDS/HIV YesNo Emphysema YesNo Miscarriage YesNo Scarlet Fever YesNo

Alcoholism YesNo Epilepsy YesNo Mononucleosis YesNo Stroke YesNo

Allergy Shots YesNo Fractures YesNo Multiple Sclerosis YesNo Thyroid Problems YesNo

Anemia YesNo Glaucoma YesNo Mumps YesNo Tonsillitis YesNo

Anorexia YesNo Goiter YesNo Osteoporosis YesNo Tuberculosis YesNo

Appendicitis YesNo Gonorrhea YesNo Pacemaker YesNo Tumors/Growths YesNo

Arthritis YesNo Gout YesNo Parkinson’s YesNo Typhoid Fever YesNo

Asthma YesNo Heart Disease YesNo Pinched Nerve YesNo Ulcers YesNo

Bleeding Disorders YesNo Hepatitis YesNo Pneumonia YesNo Vaginal Infection YesNo

Breast Lump YesNo Hernia YesNo Polio YesNo Venereal Disease YesNo

Bronchitis YesNo Herniated Disc YesNo Prostate Problems YesNo Whooping Cough YesNo

Bulimia YesNo Herpes YesNo Prosthesis YesNo Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer YesNo High Cholesterol YesNo Psychiatric Care YesNo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts YesNo Kidney Disease YesNo Rheumatoid ArthritisYesNo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemical Liver Disease YesNo Rheumatic Fever YesNo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dependency YesNo Measles YesNo Family history of any illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chicken Pox YesNo Migraine HeadacheYesNo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes YesNo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Pregnant? YesNo Due Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXERCISE** None Moderate Daily Heavy Type of Exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORK ACTIVITY** Sitting Standing Light Labor Heavy Labor  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HABITS** Smoking - Packs/Day \_\_\_\_\_\_\_\_\_\_ Alcohol - Drinks/Week \_\_\_\_\_\_\_ Coffee/Caffeine Drinks - Cups/Day \_\_\_\_\_\_\_\_\_\_\_ High Stress Level - Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ILLNESSES OR SURGERIES** DESCRIPTION DATE(S)

Falls \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken Bones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dislocation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_