

**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?[ ]  Yes[ ] No Date \_\_\_\_\_\_ Type of accident [ ] Auto [ ] Work[ ] Home [ ] 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 [ ] Yes[ ] No Emphysema [ ] Yes[ ] No Miscarriage [ ] Yes[ ] No Scarlet Fever [ ] Yes[ ] No

Alcoholism [ ] Yes[ ] No Epilepsy [ ] Yes[ ] No Mononucleosis [ ] Yes[ ] No Stroke [ ] Yes[ ] No

Allergy Shots [ ] Yes[ ] No Fractures [ ] Yes[ ] No Multiple Sclerosis [ ] Yes[ ] No Thyroid Problems [ ] Yes[ ] No

Anemia [ ] Yes[ ] No Glaucoma [ ] Yes[ ] No Mumps [ ] Yes[ ] No Tonsillitis [ ] Yes[ ] No

Anorexia [ ] Yes[ ] No Goiter [ ] Yes[ ] No Osteoporosis [ ] Yes[ ] No Tuberculosis [ ] Yes[ ] No

Appendicitis [ ] Yes[ ] No Gonorrhea [ ] Yes[ ] No Pacemaker [ ] Yes[ ] No Tumors/Growths [ ] Yes[ ] No

Arthritis [ ] Yes[ ] No Gout [ ] Yes[ ] No Parkinson’s [ ] Yes[ ] No Typhoid Fever [ ] Yes[ ] No

Asthma [ ] Yes[ ] No Heart Disease [ ] Yes[ ] No Pinched Nerve [ ] Yes[ ] No Ulcers [ ] Yes[ ] No

Bleeding Disorders [ ] Yes[ ] No Hepatitis [ ] Yes[ ] No Pneumonia [ ] Yes[ ] No Vaginal Infection [ ] Yes[ ] No

Breast Lump [ ] Yes[ ] No Hernia [ ] Yes[ ] No Polio [ ] Yes[ ] No Venereal Disease [ ] Yes[ ] No

Bronchitis [ ] Yes[ ] No Herniated Disc [ ] Yes[ ] No Prostate Problems [ ] Yes[ ] No Whooping Cough [ ] Yes[ ] No

Bulimia [ ] Yes[ ] No Herpes [ ] Yes[ ] No Prosthesis [ ] Yes[ ] No Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer [ ] Yes[ ] No High Cholesterol [ ] Yes[ ] No Psychiatric Care [ ] Yes[ ] No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts [ ] Yes[ ] No Kidney Disease [ ] Yes[ ] No Rheumatoid Arthritis[ ] Yes[ ] No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemical Liver Disease [ ] Yes[ ] No Rheumatic Fever [ ] Yes[ ] No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dependency [ ] Yes[ ] No Measles [ ] Yes[ ] No Family history of any illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chicken Pox [ ] Yes[ ] No Migraine Headache[ ] Yes[ ] No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes [ ] Yes[ ] No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Pregnant? [ ] Yes[ ] No 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_