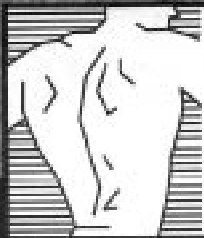


JENSEN WALK IN CHIROPRACTIC

WELCOME

1 About You

Today's Date: ____/____/____ File #: ____

Name: ____

What you prefer to be called: ____ ❑ Male ❑ Female

Birth Date: ___/___/___ Age: ____ SS#: ____

Mailing Address: ____

Driver's License#: ____

Home Phone #: ____

Other Phone #: ____

Referred By: ____

Employer ____

Employer's Address: ____

City ____ State ____ Zip ____

Occupation: ____

Work Phone #: ____ E-mail: ____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

2 Insurance Info

Co. Name: ____

Address: ____

Phone #: ____

Insured's SS#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____

Date of Birth: ___/___/___

Insured's Employer: ____

Please inform front desk of 2nd Insurance Source.

3 Reason For Visit

The reason for this visit is a result of (**please circle**): work sports, auto, trauma, chronic

Explain what happened - ____

Please describe the pain & its location: ____

When did condition begin? ____

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & Goes

Is this condition interfering with your (**please circle**): work, sleep, or daily routine

If so, please explain: ____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: ____

Have you ever been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? ____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? ____ Phone #: ____

4 In The Event Of Emergency

Who should we contact: ______________________

Relation: ______________________

Home Phone #: ______________________

Work Phone #: ______________________

Who is your Medical Doctor? ______________________ Phone ____________

5 Health History

Are You Taking Any Of The Following Medications?

❑ Nerve Pills ❑ Pain Killers (including aspirin) ❑ Stimulants
❑ Muscle Relaxers ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin
Other(s): ______________________

Have you ever had any of the following diseases/medical conditions(s)?

❑ Heart Attack/Stroke	❑ Heart Surg./Pacemaker	❑ Heart Murmur
❑ Congenital Heart Defect	❑ Mitral Valve Prolapse	❑ Artificial Valves
❑ Alcohol/Drug Abuse	❑ Venereal Disease	❑ Hepatitis
❑ HIV + /Aids	❑ Shingles	❑ Cancer
❑ Frequent Neck Pain	❑ Emphysema/Glaucoma	❑ Anemia
❑ High/Low Blood Pressure	❑ Psychiatric Problems	❑ Rheumatic Fever
❑ Severe/Frequent Headaches	❑ Kidney Problems	❑ Ulcers/Colitis
❑ Fainting/Seizures/Epilepsy	❑ Sinus Problems	❑ Asthma
❑ Diabetes/Tuberculosis	❑ Difficulty Breathing	❑ Chemotherapy
❑ Lower Back Problems	❑ Artificial Bones/Joints	❑ Arthritis

Please list any other serious medical condition(s) you have or ever had: ______________________

____

Please list anything that you may be allergic to: ______________________

____

List previous surgeries/treatments with dates: ______________________

____

List any ***PAST*** serious accidents with dates: ______________________

____

Family Health History: ______________________

____

Do you smoke? ❑ No ❑ Yes/How Much? ____ How Long? ____
Are you wearing:
❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports
What is the age of your mattress?
Is it comfortable? ❑ Yes ❑ No
For Women: Are you taking Birth Control? ❑ Yes ❑ No
Are you Pregnant? ❑ No ❑ Yes/How Long? ____________
Nursing? ❑ Yes ❑ No

Account Info 6

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

Name: ______________________

Relation: ______________________

Billing Address: ______________________

____

SSN#: ______________________

D.L.#: ______________________

Work Phone #: ______________________

Payment Method: ❑ Cash ❑ Check

____

Credit Card- Enter card # above (if accepted)

______ Initials — I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office.)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- 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, 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 and or managed care organization, 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 changes in my medical status.

Signature: ______________________ Date: ____/____/____

JENSEN WALK IN CHIROPRACTIC

WELCOME

PAIN CHART

ABOUT YOU

Name: ______________________ File #: ______________________

What is your current weight: ________ lbs., and height, ______ Ft. ______ Inches.

Please describe your condition:

____

____

Signature: ______________________ Date: ___/___/___

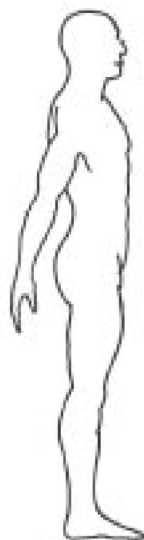
SHOW US WHERE IT HURTS

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).

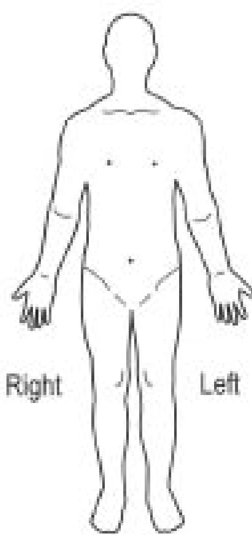
Description: ›	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol: ›	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol.

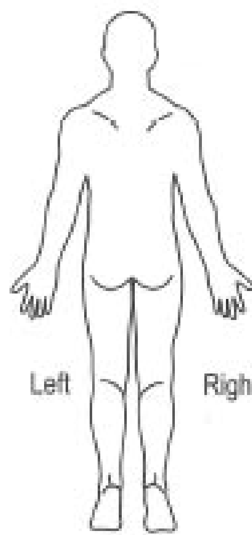
EXAMPLE



RIGHT



FRONT



BACK

LEFT

DOCTOR'S NOTES

____

____

____

____

SURGERY: YES ________ NO ________ WHEN: ________________ WHAT KIND: ________________

SYMPTOMS:	Severe	Moderate	Mild
Allergy	☐	☐	☐
Chills	☐	☐	☐
Convulsions	☐	☐	☐
Diabetic	☐	☐	☐
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Headache	☐	☐	☐
Loss of Sleep	☐	☐	☐
Loss of Weight	☐	☐	☐
Nervousness	☐	☐	☐
Neuralgia	☐	☐	☐
Numbness	☐	☐	☐
Sweats	☐	☐	☐
Wheezing	☐	☐	☐
<u>MUSCLE & JOINT:</u>			
Back Ache	☐	☐	☐
Faulty Posture	☐	☐	☐
Foot Trouble	☐	☐	☐
Hernia	☐	☐	☐
Pain Between Shoulders	☐	☐	☐
Painful Tail Bone	☐	☐	☐
Spinal Curvature	☐	☐	☐
Stiff Neck	☐	☐	☐
Tremors	☐	☐	☐
Swollen Joints	☐	☐	☐
<u>CARDIO-VASCULAR:</u>			
Hardening of Arteries	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Pain Over Heart	☐	☐	☐
Paralytic Stroke	☐	☐	☐
Poor Circulation	☐	☐	☐
Previous Heart Stroke	☐	☐	☐
Rapid Beating Heart	☐	☐	☐
Slow Beating Heart	☐	☐	☐
Swelling of Ankles	☐	☐	☐
Fractures	☐	☐	☐
Hypoglycemia	☐	☐	☐

GASTRO-INTESTINAL:	Severe	Moderate	Mild
Belching or Gas	☐	☐	☐
Colitis	☐	☐	☐
Colon Trouble	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Difficult Digestion	☐	☐	☐
Excessive Hunger	☐	☐	☐
Gall Bladder Trouble	☐	☐	☐
Hemorrhoids (Piles)	☐	☐	☐
Intestinal Worms	☐	☐	☐
Jaundice	☐	☐	☐
Liver Trouble	☐	☐	☐
Nausea	☐	☐	☐
Pain Over Stomach	☐	☐	☐
Poor Appetite	☐	☐	☐
Vomiting of Blood	☐	☐	☐
Ulcers	☐ Yes	☐ No	
<u>E.E.N.T.</u>			
Glasses	☐ Yes	☐ No	
Asthma	☐	☐	☐
Crossed Eyes	☐	☐	☐
Deafness	☐	☐	☐
Dental Decay	☐	☐	☐
Earache	☐	☐	☐
Ear Discharge	☐	☐	☐
Ear Noises	☐	☐	☐
Enlarged Glands	☐	☐	☐
Enlarged Thyroid	☐	☐	☐
Eye Pain	☐	☐	☐
Failing Vision	☐	☐	☐
Far Sightedness	☐	☐	☐
Frequent Colds	☐	☐	☐
Hay Fever	☐	☐	☐
Hoarseness	☐	☐	☐
Gum Trouble	☐	☐	☐
Nasal Obstruction	☐	☐	☐
Nose Bleeds	☐	☐	☐
Near Sightedness	☐	☐	☐
Sinus Infection	☐	☐	☐
Soar Throat	☐	☐	☐
Tonsillitis	☐	☐	☐

<u>RESPIRATORY:</u>	Severe	Moderate	Mild
Chest Pain	☐	☐	☐
Chronic Cough	☐	☐	☐
Difficult Breathing	☐	☐	☐
Spitting Up Blood	☐	☐	☐
Spitting Up Phlegm	☐	☐	☐
<u>SKIN</u>			
Boils	☐	☐	☐
Bruises	☐	☐	☐
Dryness	☐	☐	☐
Hives or Allergy	☐	☐	☐
Itching	☐	☐	☐
Sensitive Skin	☐	☐	☐
Skin Eruptions	☐	☐	☐
Varicose Veins	☐	☐	☐
<u>GENITO-URINARY</u>			
Bed Wetting	☐	☐	☐
Blood in Urine	☐	☐	☐
Frequent Urination	☐	☐	☐
Inability to Control Urine	☐	☐	☐
Kidney Infection or	☐	☐	☐
Stones	☐	☐	☐
Painful Urination	☐	☐	☐
Prostate trouble	☐	☐	☐
Pus in Urine	☐	☐	☐
<u>FOR WOMEN ONLY</u>			
Congested Breast	☐	☐	☐
Cramps or Backache	☐	☐	☐
Excessive Flow	☐	☐	☐
Hot Flashes	☐	☐	☐
Irregular Cycle	☐	☐	☐
Lumps in Breast	☐	☐	☐
Menopausal Symptoms	☐	☐	☐
Painful Menstruation	☐	☐	☐
Previous Miscarriage	☐	☐	☐
Vaginal Discharge	☐	☐	☐