before printing, if you wish. File# Date First Name MI SS# Last Mailing City State Zip Address **Physical** State **Address** City 8 Hm# Wk# Mobile E-Mail Northern City Address State Zip At Northern address from: to Phone: Sex: ☐ Female ☐ Male DL# Date of Birth Age Marital Status: ☐ M ☐ S ☐ D ☐ W #of children_ How did you ☐ Yellow pgs ☐ Radio ☐ News Publication ☐ Ins. Company hear about us? ☐ Friend/Other ⇒ Spouse's Name Employer/School Address City State Zip IN CASE OF EMERGENCY, CONTACT Relationship to Patient Name Phone #: Address Citv State Zip Will we be filing insurance for you? □ No □ Auto Accident Date ☐ Health ☐ Work Comp Supervisor ■ Medicare ■ Medicaid Additional accident paperwork must be completed Name of Insurance Co. Policy# Policy Holder Relationship to Patient PEOPLE AUTHORIZED TO ACCESS YOUR ACCOUNT: Name Relationship to patient Allowed access to: ☐ Scheduling ☐ Billing ☐ Health Information ☐ Scheduling ☐ Billing ☐ Health Information ☐ Scheduling ☐ Billing ☐ Health Information Patient Signature Date

*You are able to fill this form out on your computer

Reaching Steeping O O O O O O O O O O O O O O O O O O	D 11	EM : What pain are which travels to:	you feeling today worse when:	? List your most better when:	painful symptoms first. pain level (10=Emergency) timing
When did your pain start? Mark the areas of your pain \$\) When did your pain start? Mark the areas of your pain \$\) Or	NP^{IO} Neck Pain		·		O O O O O O O O O O O O O O O O O O O
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When did your pain start?	•		<u> </u>		On/Off
When did your pain start? Mark the areas of your pain Development of the past? Ist the most recent injury first. Or	•		<u> </u>		On/Off
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Average you had this current problem before? No Yes Details:				(
Have you been injured in the past? List the most recent injury first. Auto Work Sports Fall Other Details:	lave you had this current pro	oblem before? \(\bar{\text{No}} \)	Ves Details:∃	Les Mis	Temp:
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Primary MD	☐ Medications:				
Specialist	<u>Doctor</u> <u>Name</u>		I	Last Visit	Results related to current condition
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SOCIAL HISTORY: D Smoker: \[\text{No } \text{Yes} \] packs/\[\] day \[\text{week} \] \[\text{Alcohol: } \[\text{No } \] Yes \[\] drinks/\[\] day \[\text{week} \] or Current \[\text{Type of Work: } \] \[\text{Past or Current Type of Work: } \] 3 Activities: \[\] Golf \[\text{Tennis} \] \[\text{Running} \] \[\text{Biking} \] \[\text{Other} \] \[\text{Seasonal } \] \[\text{MoNE} \] \[\text{Seasonal } \] \[\text{MoNE} \] \[\text{Condition: } \] \[\text{Hart Disease } \] \[\text{Blood Pressure } \] \[\text{Cancer } \] \[\text{Diabetes } \] \[\text{Stroke} \] \[\text{Other} \] \[\text{cather's Side: } \] \[\text{High } \]				/ /	Good □Fair □None □Worse □N/
Smoker: No Yes packs/ day week Alcohol: No Yes drinks/ day week or only on occasion Past or Current Type of Work:	hiropractic			/ /	Good □Fair □None □Worse □N/
BWork:years			6		
ALLERGIES: NONE Seasonal Mold Pollen Dust Animals Drugs Other MILY HISTORY: NONE Condition: Heart Disease Blood Pressure Cancer Diabetes Stroke Other Mother's Side: High Low	_			Past or Current :	ks/UdayUweek or Uonly on occasion
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