INWOOD CHIROPRACTIC CENTER

7979 Inwood Road, Suite 123. Mailing Address: P.O. Box 7878, Dallas, Texas 75209.
Telephone (214) 902-0092. Fax (214) 902-4848. www.BackPro.net

PATIENT INFORMATION

DATE:__________________

NAME:____

ADDRESS:____

____
CITY STATE ZIP

HOME: ____

WORK: __________________________________ EXT: _________

EMAIL: ____

BEST TIME & PLACE TO REACH YOU: ____________________

SEX: □ M □ F AGE: ________ BIRTHDATE: __________

□ SINGLE □ MARRIED □ WIDOWED □ SEPERATED □ DIVORCED

PATIENT SS#: ____

OCCUPATION: ____

EMPLOYER: ____

EMPLOYER ADDRESS: ____

EMPLOYER PHONE: ____

SPOUSE'S NAME: ____

WHOM MAY WE THANK FOR REFERRING YOU? ________________

____

INSURANCE

Insurance Co: _________________Group #: ___________
Subscriber's Name: _______________________________
Relationship to Patient: ____________________________
Birth date: ____________ SS#______________________
Is Patient covered by additional insurance? □YES □NO
If YES, please complete the following:
Insurance Co: _________________Group #: ___________
Subscriber's Name: _______________________________
Relationship to Patient: ____________________________
Birth date: ____________ SS#______________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ________________________ and assign directly to Inwood Chiropractic Center 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

____
RESPONSIBLE PARTY SIGNATURE
__________________________ __________________
RELATIONSHIP DATE

ACCIDENT INFORMATION

Is this condition due to an accident? □ YES □ NO Date: _______

Type of accident: □ Auto □ Work □ Home □ Other

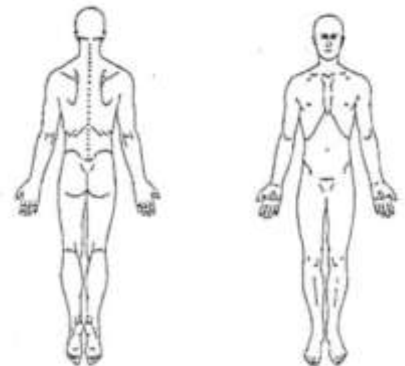
To who have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp. □ Other

Attorney Name (if applicable): _________________________

PATIENT CONDITION

Reason for visit: ____
When did your symptoms appear? ______________________________________
Is this condition getting progressively worse? □ YES □ NO □ UNKNOWN

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): ___________
Type of pain: □ SHARP □ DULL □ THROBBING □ NUMBNESS
□ ACHING □ SHOOTING □ BURNING □ TINGLING
□ CRAMPS □ STIFFNESS □ SWELLING □ OTHER

How often do you have this pain? _______________________________________
Is it constant or does it come & go? _____________________________________
Does it interfere with your: □ WORK □ SLEEP □ DAILY ROUTINE □ RECREATION
Activities or movements that are painful to perform: □ SITTING □ STANDING
□ WALKING □ BENDING □ LYING DOWN

PLEASE TURN OVER

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 Exam: __________ Blood Test: __________ Urine Test: __________
Spinal X-Ray: __________ Chest X-Ray: __________ Dental X-Ray: __________
MRI / CT-Scan / Bone Scan: ____

Mark "Yes" or "No" to indicate if you have had any of the following:

Condition		Condition		Condition		Condition	
AIDS/HIV	□ YES □ NO	Epilepsy	□ YES □ NO	Mononucleosis	□ YES □ NO	Stroke	□ YES □ NO
Alcoholism	□ YES □ NO	Fractures	□ YES □ NO	Multiple Sclerosis	□ YES □ NO	Suicide Attempt	□ YES □ NO
Allergy Shots	□ YES □ NO	Glaucoma	□ YES □ NO	Mumps	□ YES □ NO	Thyroid Problems	□ YES □ NO
Anemia	□ YES □ NO	Goiter	□ YES □ NO	Osteoporosis	□ YES □ NO	Tonsillitis	□ YES □ NO
Anorexia	□ YES □ NO	Gonorrhea	□ YES □ NO	Pacemaker	□ YES □ NO	Tuberculosis	□ YES □NO
Appendicitis	□ YES □ NO	Gout	□ YES □ NO	Parkinson's Disease	□ YES □ NO	Tumors & Growths	□ YES □ NO
Arthritis	□ YES □ NO	Heart Disease	□ YES □ NO	Pinched Nerve	□ YES □ NO	Typhoid Fever	□ YES □ NO
Asthma	□ YES □ NO	Hepatitis	□ YES □ NO	Pneumonia	□ YES □ NO	Ulcer	□ YES □ NO
Bleeding Disorders	□ YES □ NO	Hernia	□ YES □ NO	Polio	□ YES □ NO	Vaginal Infections	□ YES □ NO
Breast Lump	□ YES □ NO	Herniated Disk	□ YES □ NO	Prostate Problems	□ YES □ NO	Venereal Disease	□ YES □ NO
Bulimia	□ YES □ NO	Herpes	□ YES □ NO	Prosthesis	□ YES □ NO	Whooping Cough	□ YES □ NO
Cancer	□ YES □ NO	High Cholesterol	□ YES □ NO	Psychiatric Care	□ YES □ NO	Other __________________	
Cataracts	□ YES □ NO	Kidney Disease	□ YES □ NO	Rheumatoid Arthritis	□ YES □ NO		
Chemical Dependency	□ YES □ NO	Liver Disease	□ YES □ NO	Rheumatic Fever	□ YES □ NO		
Chicken Pox	□ YES □ NO	Measles	□ YES □ NO	Scarlet Fever	□ YES □ NO		
Diabetes	□ YES □ NO	Migraine Headaches	□ YES □ NO				
Emphysema	□ YES □ NO	Miscarriage	□ YES □ NO				

ARE YOU PREGNANT? □ YES □ NO Due Date: ____

EXERCISE

□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY

□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS

□ Smoking Packs/Day: __________________
□ Alcohol Drinks/Week: ________________
□ Coffee/Caffeine Drinks Cups/Day: __________________
□ High Stress Level Reason: ____________________

PLEASE LIST ALL PAST INJURIES & SURGERIES.

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other		

MEDICATIONS

____
____
____
____

ALLERGIES

____
____
____
____

VITAMINS/HERBS/MINERALS

____
____
____
____

CREDIT CARD AUTHORIZATION (OPTIONAL)

For my convenience, I hereby authorize Inwood Chiropractic Center to charge this credit card for any services rendered such as co-pays, deductibles, or supplies, unless otherwise stated at time of service.

Name of Cardholder: ____________________________________
Card Number: ____
Expiration Date: ______________ Security Code: _____________

Signature: ____

IN CASE OF EMERGENCY CONTACT:

NAME: ______________________________________
RELATIONSHIP: ______________________________
HOME PHONE: _________________________________
WORK PHONE: _________________________ EXT: ______