LACKEY CHIROPRACTIC CENTER NIELSON

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So that we may best serve your health care needs, please complete the following information as accurately as possible. Thank You!

Confidential Information

Legal Name: _____ _____ _____
First Name M.I. Last Name

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Gender: Male Female

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext: _____

Cell Phone: _____ - _____ - _____

Email Address: _____ @ _____

Employer: _____ Type of work: _____

Whom may we thank for referring you to our office? _____

Do you have health insurance you wish us to file? Yes No

Do you have secondary insurance through your spouse's employer? Yes No

Primary Care Physician: _____

Hobbies: _____

Authorization for Examination and/or Treatment

_____ Date: _____ / _____ / _____
Signature of Patient or Guardian

Past Health History

List known health conditions (high blood pressure, diabetes, etc.): _____

_____

Previous surgeries: _____

Are you pregnant? Yes No Due Date _____

Do you smoke? Yes No

Amount: _____ packs per day

Have you ever been treated for alcohol or substance abuse: Yes No

Have you ever been in an accident? Yes No

Please describe: _____

Any other family members with spinal related problems? _____

Present Complaint (s)

Please list the primary complaint (s) for which you are seeking help: _____

When did symptoms begin? _____

What caused this condition? _____

Type of pain? Sharp Dull Throbbing Stiff Burning Tingling

Frequency of pain? Constant Intermittent

What makes the pain better? _____

What makes the pain worse? _____

Have you ever had similar symptoms in the past? _____

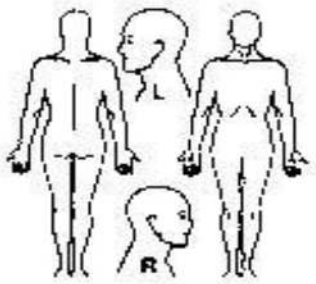
If yes, when? _____

List other doctors seen for this condition: _____

Put an **X** on the scale to indicate your present level of pain. If you are describing more than one symptom, indicate the level of pain for each:

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Possible Discomfort

Mark any areas of pain or discomfort on the figures: →



Insurance/Medicare Authorization

Please read and initial each box:

( ) I authorize use of this form on all of my insurance transmissions

( ) I authorize release of information to all of my insurance carriers

( ) I understand that I am responsible for my bill

( ) I authorize my doctor to act as my agent in helping obtain payment from my insurance carrier

( ) I authorize payment direct to my doctor

( ) I permit a copy of this authorization to be used in place of the original

Name: _____

Please Print

Signature: _____ Date ___/___/_____