For Office Use Only

Bilateral Weight Scales
R_______L______

CONFIDENTIAL PATIENT INFORMATION

Date: ________________________

Name: ____ Home Phone:________________ Cell: _________________

Address: ____ City:________________ State:______ Zip:_________

Occupation: _____________________________Employer:______________________________Phone:_____________

Birth Date: ____________________ Age: ___________ Sex: M F Marital Status: S M W D

Spouse's Name: _____________________________ # of Children: ____________

How were you referred to our office?____

Have you ever been to a Chiropractor before? _________ If yes, list names of doctors __________________________

List your chief complaints in the order of their severity:

1.____ For how long? ______________________________

2.____ For how long ______________________________

3.____ For how long? ______________________________

Females: Are you pregnant? Yes______ No_______ Not sure_______

Please list any conditions/medications____

____

____

The vast majority of our patients have been involved in dozens of impacts which could cause **VERTEBRAL SUBLUXATION**. In order for Dr. Lee to better understand your case, please list at least five of yours.

1. When was your MOST recent **Auto/Motorcycle Accident**? Date: _________________
   (Please circle) Front Back Side Other _______________
   Any treatment received? Yes ___ No ___
   If yes, what type of care?____
   Chiropractic care? Yes ___ No ___

2. When was the one before that? Date: _________________
   (Please circle) Front Back Side Other _______________
   Any treatment received? Yes ___ No
   If yes, what type of care?____
   Chiropractic care? Yes ___ No ____

Most people have a slip, strain, twist, or fall playing **sports**, at **home** or **work**, whether it was reported or not.

1. When was your most recent stress or strain? Date: _________________
   Any treatment received? Yes ___ No ___
   Chiropractic care? Yes ___ No ____
   If yes, what type of care?____

2. The one before that? Date: ________________________
   Any treatment received? Yes ___ No ___
   If yes, what type of care?____
   Chiropractic care? Yes ___ No ____

Please list any **other important traumas** (childhood traumas, illnesses, fractures, sprains, or surgeries) not mentioned:

1. Date: _______________ Briefly describe the trauma ____
   Any treatment received? Yes ____ No ____ Chiropractic care? Yes ____ No ____

2. Date: _______________ Briefly describe the trauma ____
   Any treatment received? Yes ____ No ____ Chiropractic care? Yes ____ No ____

ALL CHARGES ARE TO BE PAID WHEN SERVICES ARE RENDERED

I understand and agree that health insurance policies are an arrangement between an insurance carrier and me. I understand this office will prepare any necessary reports and forms to assist me in making a claim with my insurance company.

I am advising this office that this is not an accident claim (motor vehicle, personal or work injury), and agree that all services rendered will be charged directly to me making me personally responsible for payment.

I understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect on this account.

The initial fee paid for x-rays taken is for *analysis only*. The x-rays will remain property of this office. *Release of x-ray copies may be requested for a fee of $150.00 along with a written request from your physician*.

This office *does not* participate in the Medicare program.

Patient Signature:_______________________________________ Date:_________________________

Guardian or Spouse's Signature for Authorized Care:_____________________________________
PRINT NAME SIGNATURE

In case of emergency notify: ___________________________ Phone No.: ___________________________
Address: ____

Name of nearest relative: _____________________________ Phone No.: ____________________________
Address: ____