Patient # ______________

CONFIDENTIAL PATIENT INFORMATION

(PLEASE PRINT CLEARLY) **Date: __________________**

Name:____ SS#:____________________ Phone:__________________
Address:____ City:_________________ State:_______ Zip:___________
Occupation:____________________________ Employer:_____________________________ Phone:_______________
Address:____ City:________________ State:________ Zip:__________
Birth Date:___________________ Age: ___________ Sex M F Marital Status: S M W D
Spouse's Name:____________________________ # of Children ____________ Ages:____________________
Names of Children:____
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How were you referred to our office?____
Have you ever been to a chiropractor before?_________ If yes, Name of Doctor _________________________________
List your chief complaints in the order of their severity:
1.____ For how long?_____________________________
2.____ For how long?_____________________________
3.____ For how long?_____________________________

List other doctors consulted for these conditions:
1.____ Address:____
2.____ Address:____

List of medications which you are presently being taken:
____

Females: Are you pregnant? Yes______ No_______ Not sure_______
Please notify the doctor if you are pregnant or possibly pregnant.

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED.

2. THE FEE PAID FOR X-RAYS IS FOR ANALYSIS ONLY. THE FILM ITSELF IS THE PROPERTY OF THIS OFFICE. THEY CAN NOT BE RELEASED WITHOUT A PROPER DOCTOR'S WRITTEN REQUEST AND $150 DEPOSIT. YOUR DEPOSIT WILL BE KEPT ON FILE FOR 30 DAYS AND RETURNED WHEN YOU RETURN THE FILMS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Dr. Brad Lee's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to paid directly to Dr. Brad Lee D.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me 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. I authorize Brad Lee D.C. to obtain a credit report, if necessary.

Patient's Signature:____ **Date:**___________________________

Guardian or Spouse's Signature for Authorized Care:_____________________________________ **Date:**________________

In Case of Emergency notify:____
Name of nearest relative Relationship

____
Address Phone Number

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PURPOSE STATEMENT

The purpose of this office is to educate as many people as possible about the spinal condition called <u>Vertebral Subluxation;</u> for it is <u>Vertebral Subluxation</u> that destroys an <u>Optimal Spine</u> and destroys <u>Optimal Health</u>. Therefore, your experience in this office will not only be of healing, but also learning the <u>TRUTH</u> about health.

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The vast majority of our patients have been involved in dozens of impacts that could cause **VERTEBRAL SUBLUXATION**. So Dr. Lee can better understand your case please list at least 5 of yours.

1. When was your MOST recent **Auto Accident/Motorcycle**? Date: ________________
   Speed? _________mph (please circle) Front Back Side Other _______________
   Any treatment received? Yes ___ No ___ If yes, what?___________________________ Chiropractic care? Yes ___ No ___
2. When was the one before that? Date: ________________
   Speed? _________mph (please circle) Front Back Side Other _______________
   Any treatment received? Yes ___ No ___ If yes, what?___________________________
   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 ___ If yes, what?___________________________
   Chiropractic care? Yes ___ No ____
2. The one before that? Date: _________________________
   Any treatment received? Yes ___ No ___ If yes, what? ___________________________
   Chiropractic care? Yes ___ No ____

THANK YOU FOR LISTING YOUR ACCIDENT HISTORY. NOW, WE WOULD LIKE YOU TO ANSWER THE NEXT SECTION ABOUT YOUR CURRENT HEALTH CONDITIONS.

1. Vertebral subluxation can put pressure on nerves for a long period of time. How long have you had:

Neck pain/stiffness	__________	Rib problem	___________
Headache	__________	Low Back pain	___________
Shoulder pain	__________	Hip/Groin pain	___________
Arm/Hand pain	__________	Leg pain	___________
High Blood Pressure	__________	Dizziness	___________
Allergy	__________	Other	___________
Upper/Mid Back pain	__________		

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

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

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

Patient's Signature: ______________________________________ Date: ___________________