

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 Doctor _____

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 _____

WE WOULD LIKE YOU TO COMPLETE THE FOLLOWING ABOUT YOUR CURRENT HEALTH CONDITIONS.

Please check all that applies and list medications you are taking.

Headaches _____

Allergies _____

Neck Pain/Stiffness _____

High Blood Pressure _____

Shoulder Pain _____

Diabetes _____

Upper Back Pain _____

Cholesterol _____

Mid Back Pain _____

Other Conditions/Medications _____

Low Back Pain _____

Rib Pain _____

Arm/Hand Pain _____

Hip/Groin Pain _____

Leg Pain _____

The vast majority of our patients have been involved in dozens of impacts that 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? _____
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? _____
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 ___

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 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 be paid directly to Brad Lee, D.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 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.

Patient Signature: _____ Date: _____

Guardian or Spouse's Signature for Authorized Care: _____ Date: _____

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

Address Phone Number