

# PATIENT PERSONAL / CONFIDENTIAL DATA

No. \_\_\_\_\_ Date: \_\_\_\_\_

Male  Female  Married  Single  Widowed  Divorced  
How did you learn of this clinic? \_\_\_\_\_ Who referred you? \_\_\_\_\_

Patient: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

List any medications currently taking: \_\_\_\_\_

Have you ever consulted a chiropractor in the past?  Yes  No Date of last adjustment: \_\_\_\_\_

Name of **Chiropractor-or** Clinic: \_\_\_\_\_ For what problem? \_\_\_\_\_

Have you been in an automobile accident in the:  Past Year  Past 5 Years  Never

Have you recently had any X-rays taken?  No  Yes, When \_\_\_\_\_

List all surgeries that you have had: \_\_\_\_\_

Have you, or anyone in your family had a history of: (I= self, M=mom, D=dad, S=sibling, O=other)

Arthritis  Back Disorders  Cancer  Diabetes  Heart Disease  High Blood Pressure  Scoliosis  Other \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse Job: \_\_\_\_\_ Spouse Phone #: \_\_\_\_\_ (circle) Work Cell

Your cell phone #: \_\_\_\_\_ No. of Children: \_\_\_\_\_ Names: \_\_\_\_\_

Nearest relative **not** living with you? \_\_\_\_\_ Phone #: \_\_\_\_\_

Who is responsible for payment?  Self  Spouse  Other \_\_\_\_\_

Purpose of this appointment / Major Complaint: \_\_\_\_\_ Location? \_\_\_\_\_

Date of onset of symptoms: \_\_\_\_\_ What time of day did the pain start? \_\_\_\_\_ Q A M O P M

How did this accident occur?  On the Job  Auto  Other \_\_\_\_\_

Is there **anything** that makes your condition Worse? \_\_\_\_\_ Better? \_\_\_\_\_

Have you ever had this problem, or a similar problem before?  No  Yes, explain: \_\_\_\_\_

Have you seen any other Doctor for this condition?  No  Yes, Who? \_\_\_\_\_

Did you get any relief? \_\_\_\_\_

Overall, has the problem been:  Getting Worse  Staying the same  Getting Better

### INSURANCE INFORMATION

*I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.*

### ASSIGNMENT OF BENEFITS

I hereby authorize ASHLOCK CHIROPRACTIC to release any information necessary to process this claim and ASSIGN ALL BENEFITS payable directly to ASHLOCK CHIROPRACTIC. I waive the Statute of Limitations regarding my doctor's right to recover. I understand that whatever amounts not collected from insurance proceeds, (whether it be all or part of what is due) I PERSONALLY OWE ASHLOCK CHIROPRACTIC. If collection or legal actions should become necessary in payment of services rendered by ASHLOCK CHIROPRACTIC, I understand that I will be PERSONALLY responsible for all fees incurred by ASHLOCK CHIROPRACTIC made to collect the payment due. Please make all checks payable to: ASHLOCK CHIROPRACTIC, L.L.C., 12899 E. 79th St N. #101, Owasso, OK 74055

### CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

### ASHLOCK CHIROPRACTIC \* NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I have received the "Notice of Privacy Practices" for Ashlock Chiropractic.  
 I understand that if I have any questions or concern about Ashlock Chiropractic's "Notice of Privacy Practices" that I should contact the Privacy Officer or a staff member of Ashlock Chiropractic.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_  
Parent's or Guardian's Signature: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?  
 YES  NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing-loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

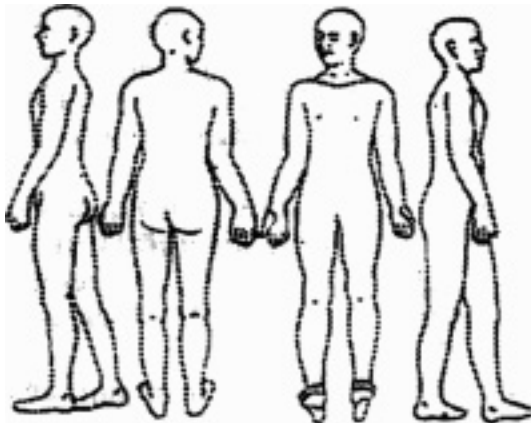
## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- \_\_\_\_\_

## SYMPTOM LOCALIZATION



P \_\_\_\_\_ Pain                      T \_\_\_\_\_ Tender  
 N \_\_\_\_\_ Numb                    H \_\_\_\_\_ Hypoesthesia  
 S \_\_\_\_\_ Spasm

### Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Sign \_\_\_\_\_

..... DO NOT WRITE BELOW THIS LINE.....

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Patient Accepted?  Yes  No      Doctor's Signature \_\_\_\_\_

# PATIENT INTRODUCTION CARD

No. \_\_\_\_\_ Date: \_\_\_\_\_

Name ( Mr. Mrs. Miss Ms. ): \_\_\_\_\_ Phone (Home): \_\_\_\_\_  
(Last, First, MI)

Address: \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Office Address: \_\_\_\_\_ Phone (Office): \_\_\_\_\_

Previous Chiropractic Care \_\_\_\_\_ Yes \_\_\_\_\_ No Doctor's Name: \_\_\_\_\_

Name of your Insurance Company: \_\_\_\_\_

Major Complaint: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Who (or what source) referred you? \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*