Date_____

Patient Information

Name_____
Address_____
_____
City State Zip
Sex ¸ M ¸ F **Age**_____**Birthday**_____
Single ¸ Married ¸ Widowed ¸ Divorced
Patient SS#_____
Occupation_____
Employer_____
Employer Address_____
Employer Phone_____
Spouse's Name_____
Birthday_____ **SS#**_____
Occupation_____
Spouse's Employer_____
Spouse's Employer Phone#_____
Whom may we thank for referring you?
_____

PHONE NUMBERS

Home_____ **Work**_____ **Ext**____

Cell_____ **Email**_____

Insurance Information

Who is responsible for this account? _____
Insurance Co._____
Policy # _____
Group # _____
Subscriber's Name_____
Birthdate_____**SS#**_____
Relationship to Patient_____
Additional Insurance_____
Insurance Co._____
Group#_____**Policy#**_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dudko Chiropractic LLC all insurance benefits, if any otherwise Payable to me for services rendered. I understand that I am financially responsible for all charges whether or not Paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

_____
Date

_____
Relationship **Date**

ACCIDENT INFORMATION

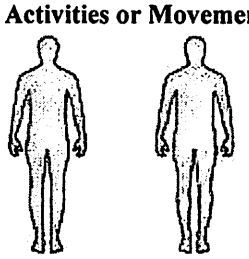
Is condition due to an accident? ¸ Yes ¸ No
Type of Accident ¸ Auto ¸ Work ¸ Other
To whom have you made a report of your Accident? ¸ Auto Insurance ¸ Employer Workers Comp. ¸ Other
Attorney's Name (if Applicable) _____

Patient Information

Reason for Visit_____ **When did your symptoms appear?** _____

Is this Condition Progressively Getting Worse? ¸ Yes ¸ No ¸ Unknown

Mark an X on the picture (below) on a Pain Scale from 1 (least pain) to 10 (worst pain). _____
Type of pain ¸ Sharp ¸ Dull ¸ Throbbing ¸ Numbness ¸ Achy ¸ Shooting ¸ Burning ¸ Tingling ¸ Cramps ¸ Stiffness ¸ Swelling ¸ Other
How Often Do You Have This Pain? ¸ Constant ¸ Intermittent
Activities or Movements That Are Difficult to Perform ¸ Sitting ¸ Standing



Label your pain with X's

Health History

What treatments have you had for your current condition? ¸ Medication ¸ Surgery ¸ Physical Therapy ¸ Chiropractic ¸ None ¸ Other _____

Name of other physicians who have treated your current condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Spinal Exam _____
Chest X-Ray _____ Urine Test _____ Dental X-Ray _____
MRI, CT, BONE SCAN, EMG/NVC _____

Please Mark a Yes o r No to indicate if you have had any of the following:

AID/HIV	¸Yes	¸No	**Emphysema**	¸Yes	¸No
Alcoholism	¸Yes	¸No	**Epilepsy**	¸Yes	¸No
Allergy Shots	¸Yes	¸No	**Fracture**	¸Yes	¸No
Anemia	¸Yes	¸No	**Glaucoma**	¸Yes	¸No
Anorexia	¸Yes	¸No	**Goiter**	¸Yes	¸No
Appendicitis	¸Yes	¸No	**Gonorrhea**	¸Yes	¸No
Arthritis	¸Yes	¸No	**Gout**	¸Yes	¸No
Asthma	¸Yes	¸No	**Heart Disease**	¸Yes	¸No
Bleeding Disorder	¸Yes	¸No	**Hepatitis**	¸Yes	¸No
Breast Lump	¸Yes	¸No	**Hernia**	¸Yes	¸No
Bronchitis	¸Yes	¸No	**Herniated Disk**	¸Yes	¸No
Bulimia	¸Yes	¸No	**Herpes**	¸Yes	¸No
Cancer	¸Yes	¸No	**High Cholesterol**	¸Yes	¸No
Cataracts	¸Yes	¸No	**Kidney Disease**	¸Yes	¸No
Chemical Dependency	¸Yes	¸No	**Liver Disease**	¸Yes	¸No
Chicken Pox	¸Yes	¸No	**Measles**	¸Yes	¸No
Diabetes	¸Yes	¸No	**Migraine**	¸Yes	¸No

Miscarriage	¸Yes	¸No	**Suicide Attempt**	¸Yes	¸No
Mononucleosis	¸Yes	¸No	**Thyroid Problems**	¸Yes	¸No
Multiple sclerosis	¸Yes	¸No	**Tonsillitis**	¸Yes	¸No
Mumps	¸Yes	¸No	**Tuberculosis Tumors**	¸Yes	¸No
Osteoporosis	¸Yes	¸No	**Growths**	¸Yes	¸No
Pacemaker	¸Yes	¸No	**Typhoid Fever**	¸Yes	¸No
Parkinson's	¸Yes	¸No	**Ulcers**	¸Yes	¸No
Pinched Nerve	¸Yes	¸No	**Vaginal Infections**	¸Yes	¸No
Pneumonia	¸Yes	¸No	**Venereal Disease**	¸Yes	¸No
Polio	¸Yes	¸No	**Whooping Cough**	¸Yes	¸No
Prostate Problems	¸Yes	¸No	**Other**	¸Yes	¸No
Prosthesis	¸Yes	¸No	**Are You Pregnant?**	¸Yes	¸No
Psychiatric Care	¸Yes	¸No			
Rheumatoid Arthritis	¸Yes	¸No	**LMP** _____		
Rheumatic Fever	¸Yes	¸No			
Scarlet Fever	¸Yes	¸No	**Due Date** _____		
Stroke	¸Yes	¸No			

Exercise: ¸ None ¸ Moderate ¸ Daily ¸ Heavy

Work Activities: ¸ Sitting ¸ Standing ¸ Light Labor ¸ Heavy Labor

Habits: ¸ Smoking - Packs/Day _____
¸ Alcohol – Drinks/Week _____
¸ Coffee/Caffeine Drinks – Cups/Day _____
¸ High Stress – Reason _____

Injuries/Surgeries You Have Had – Please describe below

_____ **Date:** _____
_____ **Date:** _____

Med/Vits currently taking: _____ **Allergies to Medications:** _____

Pertinent Family History

_____
_____