WELCOME
HEMINGWAY SPINAL CARE CENTER
Personal Information

Name: _____ Today's Date: _____
Last First Mi Mr Mrs Ms Dr

Home Address: _____
Street City State Zip

Telephone: (_____)_____ Social Security #:_____Drivers License #:_____

Age:_____ Birthdate:____/____/____ Sex: [ ] Male [ ] Female Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced No. Children:_____

Occupation:_____Employer:_____Wk#:(_____)_____Years Employed:_____

Spouse Name:_____ Occupation:_____Employer:_____Social Security#:_____

Person Responsible for this account:_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT.

Please describe your problem and how it began. Date problem began: ____/____/____ _____

_____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

How often are your symptoms present?	[ ] Intermittently	[ ] Occasionally	[ ] Frequently	[ ] Constantly
Describe your current pain/symptoms:	[ ] Sharp/Stabbing	[ ] Throbbing	[ ] Aches	
	[ ] Dull	[ ] Soreness	[ ] Weakness	
	[ ] Numbness	[ ] Shooting	[ ] Gripping	
	[ ] Burning	[ ] Tingling	[ ] Other_____	
Since it began, is your problem:	[ ] Improving	[ ] Getting worse	[ ] No Change	
What makes the problem better?	[ ] Nothing	[ ] Lying down	[ ] Walking	
	[ ] Standing	[ ] Sitting	[ ] Movement	
	[ ] Exercise	[ ] Inactivity/rest	[ ] Other_____	
What makes the problem worse?	[ ] Nothing	[ ] Lying down	[ ] Walking	
	[ ] Standing	[ ] Sitting	[ ] Movement	
	[ ] Exercise	[ ] Inactivity/rest	[ ] Other_____	
Can you perform your daily home activities?	[ ] Yes	[ ] Yes, with help	[ ] Not at all	
Do you exercise?	[ ] Yes, almost daily	[ ] Yes, occasionally	[ ] Not at all	
Describe your job requirements:	[ ] Mainly sitting	[ ] Light labor	[ ] Heavy labor	
Can you perform your daily work activities?	[ ] Yes, all activities	[ ] Only some	[ ] Not at all	
Describe your stress level:	[ ] None to mild	[ ] Moderate	[ ] High	

What treatment(s) have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)_____

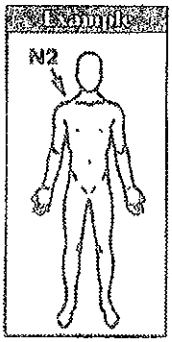
_____

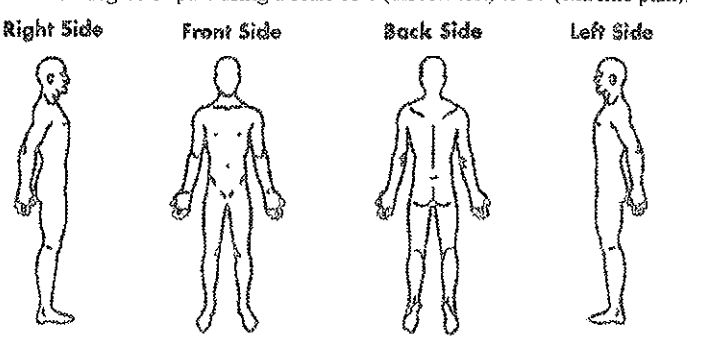
Have you had X-rays, MRI or other tests for this condition? What tests and when?_____

_____

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness . . . . . .N
Pins & Needles . . . . .P
Burning . . . . . .B
Aching . . . . . .A
Stabbing . . . . . S





CONTINUED ON BACK

Current Medications _____

Hospitalizations/Surgical Procedures _____

Do you have a permanent disability rating? [ ] yes [ ] no Location _____

Date rating received ____/____/____ Rating percentage _____%

Medical History

If you have ever had a listed symptom in the *past,* please check that symptom in the *Past Column.*
If you are *presently* troubled by a particular symptom, check that symptom in the *Present Column.*
KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Present	Condition
[ ]	[ ]	Neck pain
[ ]	[ ]	Shoulder pain (R____L____)
[ ]	[ ]	Pain in upper arm or elbow (R___ L___)
[ ]	[ ]	Hand pain (R___ L___)
[ ]	[ ]	Wrist pain (R___ L___)
[ ]	[ ]	Upper back pain
[ ]	[ ]	Lower back pain
[ ]	[ ]	Pain in upper leg or hip (R___ L___)
[ ]	[ ]	Pain in lower leg or knee (R___ L___)
[ ]	[ ]	Pain in ankle or foot (R___ L___)
[ ]	[ ]	General fatigue
[ ]	[ ]	Depression
[ ]	[ ]	Asthma
[ ]	[ ]	Chronic cough
[ ]	[ ]	Emphysema (chronic lung disorders)
[ ]	[ ]	Chronic sinusitis
[ ]	[ ]	Difficulty in swallowing
[ ]	[ ]	Diabetes
[ ]	[ ]	Headache
[ ]	[ ]	Jaw pain
[ ]	[ ]	Tinnitus (ear noises)
[ ]	[ ]	Visual disturbances
[ ]	[ ]	Dizziness
[ ]	[ ]	Abdominal pain
[ ]	[ ]	Prostate problems
[ ]	[ ]	Kidney stones
[ ]	[ ]	Loss of bladder control
[ ]	[ ]	Constipation/irregular bowel habits

Past	Present	Condition
[ ]	[ ]	Irritable colon
[ ]	[ ]	Colitis
[ ]	[ ]	Hepatitis
[ ]	[ ]	Liver/gallbladder problems
[ ]	[ ]	Ulcer
[ ]	[ ]	Muscular incoordination
[ ]	[ ]	Swelling, Stiffness of joint(s)
[ ]	[ ]	Arthritis
[ ]	[ ]	Rheumatoid arthritis
[ ]	[ ]	Heartburn/indigestion
[ ]	[ ]	Angina
[ ]	[ ]	Heart attack (date) _____
[ ]	[ ]	Aortic aneurysm
[ ]	[ ]	Chest pains
[ ]	[ ]	High blood pressure
[ ]	[ ]	Rapid heart beat
[ ]	[ ]	Stroke (date) _____
[ ]	[ ]	Loss of appetite
[ ]	[ ]	Abnormal weight [ ] Gain [ ] Loss
[ ]	[ ]	Anorexia/Bulimia
[ ]	[ ]	Tumor, explain_____
[ ]	[ ]	Cancer, explain _____
[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Epilepsy
[ ]	[ ]	Fainting
[ ]	[ ]	Other _____
[ ]	[ ]	Drug or alcohol dependence
[ ]	[ ]	Endometriosis

If a family member has had any of the following, please mark the appropriate box:

[ ] Cancer Family member _____

[ ] High blood pressure Family member _____

[ ] Chronic back problems Family member _____

[ ] Lung problems Family member _____

[ ] Chronic headaches Family member _____

[ ] Lupus Family member _____

[ ] Diabetes Family member _____

[ ] Rheumatoid arthritis Family member _____

[ ] Heart problems Family member _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

FINANCIAL & INSURANCE INFORMATION

Patient Name:_____ **Patient Social Security Number:**_____ **Patient Birthdate:**___/___/___

Primary Insurance: Chiropractic Coverage Yes____ No____

Insurance Co. Name:_____ Phone #: (___)_____ Group # (Plan, Local or Policy #):_____

Insurance Co. Address:_____
Street/ PO Box City State Zip

Insured's Name:_____ Insured's Social Security #:_____ Insured's Birthdate:___/___/___ Relation:_____

Insured's Employer:_____ Employer's Address:_____
Street/PO Box City State Zip

Secondary Insurance: Chiropractic Coverage Yes____ No____

Insurance Co. Name:_____ Phone #: (___)_____ Group # (Plan, Local or Policy #):_____

Insurance Co. Address:_____
Street/ PO Box City State Zip

Insured's Name:_____ Insured's Social Security #:_____ Insured' Birthdate:___/___/___ Relation:_____

Insured's Employer: _____ Employer's Address:_____
Street/PO Box City State Zip

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If thepatient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/ or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/ or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

_____
Signature Date

I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I,(We), the undersigned patient and/ or responsible party hereby jointly authorize this office, its agents/ employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I (We), authorize the release and disclosure of any and all of my medical records to any other entity, including , but not limited to, referring physicians, hospitals, or other health care providers. which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I,(We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We) authorize this offic and/ or its employees to release, via fax machine, medical records which are needed in order to provide patient with the most appropriate medical care.

I,(We), authorize and request that payment of any third-party or insurance company benefits be made to this office for any services furnished to patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

_____ _____
Signature of Patient Date Signature of Insured Date