Tree of Life
CHIROPRACTIC INC.

PATIENT INFORMATION

Date _____

Patient_____

Address_____

City_____ State_____ Zip_____

Home Phone _____

Cell Phone _____

Email_____

DOB:_____ Age: _____Sex: ◊ M ◊ F

◊Single ◊Married ◊Divorced ◊Widowed ◊Other

Patient SS# _____-_____-_____

Whom may we thank for referring you? _____

Employment: Full-time Part Time Student Retired

Occupation: _____

Employer: _____

Name of Medical Doctor:

_____

Facility_____ Ph._____

INSURANCE INFORMATION

Insurance Co. _____

Insurance ID: _____

Subscriber's Name _____

Relationship to Patient _____

Birth date _____ Group#_____

Is patient covered by additional insurance? ◊YES ◊NO

Insurance Co._____

Subscriber's Name _____

Relationship to Patient _____

Birth date _____ Group #_____

I, the undersigned certify that I (or my dependent) have insurance coverage with the company listed above. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to assist and secure the payment of benefits for you. We will accept assignment for all BCBS PPO policies. Medicare patients will be charged at the time of service and all paperwork will be submitted for reimbursement to the patient directly.

I authorize the use of this signature on all insurance submissions.

X _____

Signature Relation to Pt. Date

PHONE CONTACT

Best time/place to contact you :

◊AM ◊PM ◊Home ◊Cell

In case of emergency, contact:

Name_____

Phone _____

ACCIDENT INFORMATION

Is condition due to an accident? ◊ YES Date____ ◊ NO

Type of accident ◊Auto ◊Work ◊Home ◊Other

Has accident been reported to ◊Auto Insurance

◊Employer ◊Workers Comp ◊Other

Attorney/Contact_____

PRIMARY COMPLAINT

If you have more than one current complaint, please ask for an additional forms.

Reason for visit _____

When did symptoms appear? _____

Is condition getting progressively worse? ◊ YES ◊NO ◊Unknown

Please mark on picture at **right** to show where your discomfort is →

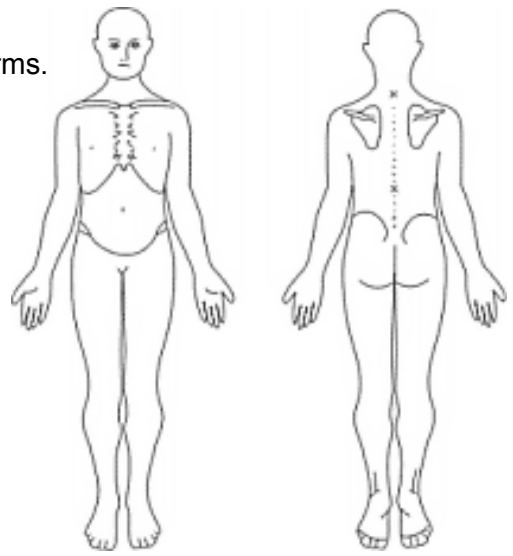
Type of pain: ◊Sharp ◊Dull ◊Throbbing ◊Numbness ◊Other _____

Time of day it is worse ◊AM ◊PM What % of day in pain _____

Does it interfere with ◊Work ◊Sleep ◊Recreation ◊Daily Routine_____

Is there anything you do that relieves the pain? _____

What makes the symptoms worse? _____



PREVIOUS TREATMENTS

Previous treatments for this condition, including self-treatment: _____

_____

Have you had X-Rays and/or MRIs of this area within the past 5 years? ◊ YES ◊ NO

If YES, we may need to contact your doctor for a copy of all studies. Dr. _____

Address_____ Phone_____

SOCIAL HISTORY

Alcohol: _____ None _____Drinks/week

Tobacco: _____None_____ Cigarettes / Packs (circle one) per day.

Caffeine: _____None _____Cups of Coffee / Tea / 12 oz. Sodas (circle one) per day.

Exercise: _____None _____Mild _____ Moderate _____Heavy

Things you do for fun/relaxation: _____

MEDICATIONS

Medication Reason Year Started

_____

_____

_____

_____

_____

SURGICAL HISTORY

Year: Surgery: Outcome:

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY MEDICAL HISTORY

*Place **X** if applies to you, or indicate; **F**ather, **M**other, **B**rother, **S**ister, **G**randparent

Diabetes_____ Stroke_____ Hypertension_____ Cancer_____ Heart Disease_____ Psoriasis_____ Lupus_____

Headache/Migraine_____ Rheumatoid Arthritis_____ Asthma____ IBS_____ M.S._____ GURD_____ Gout_____

Acid Reflux_____ Mental Illness_____ Epilepsy_____ Allergies_____ Bleeding Disorders_____ Thyroid Dis._____

Miscarriage_____

Is there a possibility you are pregnant? ◊ YES ◊ NO Due Date _____

NOTES_____

_____

_____

Updated 6/2015