Sigafoose & Jackson Family Chiropractic Date_____

	First Name				_ M.I	
Address	City/State				Zip	
Home Phone V	Vork Pl	none			S.S. #	
Age Birthdates		Se	x N	Aarital Sta	tus	
Number of Children Name/Age	es					
Occupation			Empl	oyer		
Referred by						
Medications						
Surgeries						
Auto Accidents			Serious Falls	s/Injuries _		
Is your condition due to a work injury?	Vec	No	(If yes nl	esse fill o	ut #3 below)	
Is your condition due to a work infuly? Is your condition due to an auto accident?			· · · I		ut #2 below)	
Is there any chance that you are pregnant?	Yes	No	(II yes, pla		$\pi \pi = 0000 \text{ J}$	
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What is your major complaint?						
What is your major complaint? How long have you had this condition?						
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Please check all that apply

Neck	Headache	Arms	Hands
Upper Back	Shoulder (R/L)	Chest	Abdomen
Mid Back	Low Back	Hips	Legs
Knees	Feet		
Anxiety	Swelling	Fainting	Neuritis
Nausea/Vomiting	Tension	Pain behind eyes	Fatigue
Tremors	Sinus Trouble	Depression	Restricted/ Motion
Excessive Perspiration	L		Motion

1. Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature

2. **Release of Information**

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and/or attorney involved in this case, and hereby release this clinic of any consequence thereof.

Patient Signature

3. **Financial Responsibility**

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

Patient Signature

Parent or Guardian Signature Authorizing Care

Date

Date

Date

Date