Today's Date: _____

# Sigafoose and Jackson Family Chiropractic

## PLEASE PRINT CLEARLY

NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

Social Security #: _____ EMAIL: _____

PHONE: Home: _____ Work: _____ Cell: _____

SEX: M F MARITAL STATUS: S M D W Number of Children _____

OCCUPATION: _____ EMPLOYER: _____

REFERRED BY: _____ Previous Chiropractic Care? YES NO When? _____

Surgeries? _____
Medications of any kind? _____

Are you pregnant? YES NO Due Date: _____

Do you have insurance? YES NO (Please give the front desk girl your card for copying)
If not you....
Name & DOB and Relationship to insured: _____

Is complaint due to: Work Auto If so, date of incident: _____
(Ask front desk girl for the appropriate paperwork)

Current Complaints? _____
(describe complaint in detail and draw on body below)
How long has this been going on? _____

Any episode or injury that brought you in? _____

MUST CIRCLE ALL THAT APPLY

Pain is: Severe Moderate Mild Minimal

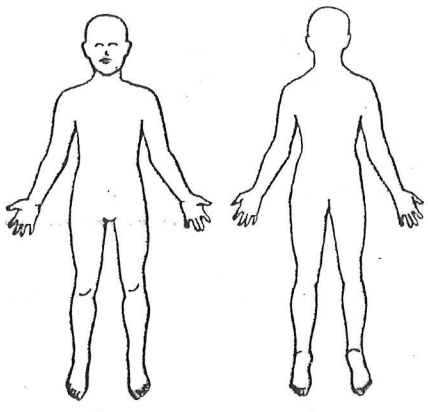
Sharp Dull Electric Burning Achy
Stiffness Tingly Numbing Sore

Pain is: Constant Occasional

What makes pain better: _____
What makes pain worse: _____

Pain scale: (best)1 2 3 4 5 6 7 8 9 10 (worst)

PLEASE MARK AREA(S) OF PAIN CLEARLY



# Please check all that apply

| | | | |
|---|---|---|---|
| _____ Neck | _____Headache | ____Arms | ____Wrists |
| _____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 | | | |

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 Date

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 Date

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 Date

_____ _____

Parent or Guardian Signature Authorizing Care Date