

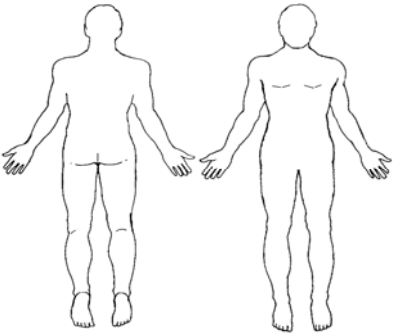
Patient Information	
Date _____	
Patient _____	
Address _____	
_____	_____
<i>City</i>	<i>State</i>
_____	<i>Zip</i>
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____ Birthdate _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Patient SS# _____	
Occupation _____	
Employer _____	
Employer Address _____	
Employer Phone _____	
Spouse's Name _____	Birthdate _____
Occupation _____	SS# _____
Employer _____	
Whom may we thank for referring you? _____	

Phone Numbers	
Home _____	Work _____
Best time and place to reach you _____	
<b>IN CASE OF EMERGENCY, CONTACT:</b>	
Name _____	Relationship _____
Home # _____	Work # _____

Insurance	
Who is responsible for this account? _____	
Relationship to Patient _____	
Insurance Co. _____	Group# _____
Is patient covered by additional insurance?      Yes      No	
Subscriber's Name _____	
Birthdate _____	SS# _____
Relationship to Patient _____	
Insurance Co. _____	Group# _____
<b>ASSIGNMENT AND RELEASE</b>	
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Chonzena 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 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.	
_____	
<i>Responsible Party Signature</i>	
_____	
<i>Relationship</i>	<i>Date</i>

Accident Information	
Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date _____	
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	
To whom have you made a report of your accident?	
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp. <input type="checkbox"/> Other	
Attorney name (if applicable) _____	

Patient Condition	
Reason for Visit _____	Mark an X on the picture where you continue to have pain, numbness, or tingling.
When did your symptoms appear? _____	
Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____	
Type of pain <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching	
<input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other	
How often do you have this pain? _____	
Is it constant, or does it come and go? _____	
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation	
Activities or movements that are painful to perform <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	



## HEALTH HISTORY

What treatments have you already received for your condition?     Medications     Surgery     Physical Therapy  
 Chiropractic Services     None     Other \_\_\_\_\_

How long since your last:	Less than 6 mo.	6-12 mo.	1-5 yrs.	5+ yrs.	Never
Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Miscarriage	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Alcoholism	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mononucleosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergy Shots	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fractures	<input type="checkbox"/> YES <input type="checkbox"/> NO	Multiple Sclerosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Suicide Attempt	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mumps	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anorexia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Goiter	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tonsillitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Appendicitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gonorrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gout	<input type="checkbox"/> YES <input type="checkbox"/> NO	Parkinson's Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tumors, Growths	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pinched Nerve	<input type="checkbox"/> YES <input type="checkbox"/> NO	Typhoid Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breast Lump	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Polio	<input type="checkbox"/> YES <input type="checkbox"/> NO	Vaginal Infections	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herniated Disk	<input type="checkbox"/> YES <input type="checkbox"/> NO	Prostate Problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bulimia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Whooping Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other _____	
Cataracts	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatoid Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Chemical Dependency	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Chicken Pox	<input type="checkbox"/> YES <input type="checkbox"/> NO	Measles	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Migraine	<input type="checkbox"/> YES <input type="checkbox"/> NO				
		Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO				

### EXERCISE

- None
- Moderate
- Daily
- Heavy

### WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

### HABITS

- Smoking                      Packs/Day \_\_\_\_\_
- Alcohol                              Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Drinks      Cups/Day \_\_\_\_\_
- High Stress Level              Reason \_\_\_\_\_

Are you pregnant?     YES  NO                      Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS
