BACK AND NECK PAIN CHIROPRACTIC CLINIC
A STEVEN BARHAM PROFESSIONAL CORPORATION

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PERSONAL INFORMATION

NAME_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____ HOME PHONE_____

CELL PHONE_____ EMAIL _____

SSN_____ DATE OF BIRTH_____ AGE_____

HEIGHT_____ WEIGHT_____ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ #CHILDREN_____

EMPLOYER_____ OCCUPATION_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____ WORK PHONE_____

NAME OF SPOUSE (OR PARENT)_____

MEDICAL INFORMATION

FAMILY PHYSICIAN:_____ WHERE ARE THEY LOCATED?_____

HAVE YOU EVER HAD CHIROPRACTIC CARE? IF YES, DOCTOR NAME_____

DATE OF LAST VISIT_____

IF YOU ARE EXPERIENCING ANY PAIN (NECK PAIN, MID BACK PAIN, LOW BACK PAIN, ETC.) HEALTH PROBLEMS, SYMPTOMS, AND/OR COMPLAINTS, PLEASE LIST IN ORDER OF SEVERITY:

1._____ FOR HOW LONG?_____
2._____ FOR HOW LONG?_____
3._____ FOR HOW LONG?_____
4._____ FOR HOW LONG?_____

HAS THIS PROBLEM BEEN GETTING WORSE ☐ STAYING THE SAME ☐

HAVE YOU EVER EXPERIENCED ANY OF THESE COMPLAINTS WHILE WORKING? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE WHAT ACTIVITIES MAY BE CAUSING THESE COMPLAINTS:

_____

ARE THERE ANY OTHER ACTIVITIES , INCIDENTS, OR EVENTS OUTSIDE WORK THAT MAY HAVE CAUSED THESE COMPLAINTS? IF YES, EXPLAIN:

_____

HAVE YOU AT ANY TIME IN THE PAST SUFFERED A WORK INJURY? IF YES, EXPLAIN:

_____

DO YOU HAVE AN ATTORNEY REPRESENTING YOU FOR THIS WORK INJURY? ☐ YES ☐ NO

IF YES, WHO IS YOUR ATTORNEY?_____

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT IN THE LAST 12 MONTHS? ☐ YES ☐ NO

IF YES, DATE OF THE AUTO ACCIDENT_____

DO YOU HAVE AN ATTORNEY REPRESENTING YOUFOR THIS AUTO ACCIDENT? ☐ YES ☐ NO

IF YES, WHO IS YOUR ATTORNEY?_____

HOW MANY PASSANGERS WERE IN THE CAR WITH YOU?_____

LIST DOCTORS CONSULTED FOR THESE CONDITIONS: 1._____ 2._____

IF DUE TO AN ACCIDENT, WHO IS YOUR AUTO INSURANCE COMPANY?_____

MEDICAL HISTORY

HAVE YOU EVER HAD ANY SURGERIES OR HOSPITALIZATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST:_____

PLEASE LIST ANY CURRENT OR PAST INJURIES AND ILLNESSES NOT LISTED ABOVE:

_____

PLEASE CHECK ALL MEDICATIONS (OVER THE COUNTER AND/OR PRESCRIBED) YOU ARE CURRENTLY TAKING: ☐ ASPIRIN ☐ TYLENOL ☐ PAIN KILLERS ☐ MUSCLE RELAXERS ☐ INSULIN ☐ BIRTH CONTROL PILLS ☐ SLEEPING PILLS ☐ ANTI-DEPRESSANTS ☐ OTHERS_____

INSURANCE INFORMATION

HEALTH INSURANCE COMPANY NAME_____ POLICY HOLDER_____

CLAIM ADDRESS_____

POLICY NUMBER_____

SECONDARY INSURANCE /SPOUSE INSURANCE (IF DIFFERENT FROM ABOVE):_____

FOR EACH OF THE SIX CATEGORIES OF DAILY LIVING LISTED, **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** 0 MEANS NO DISABILITY AT ALL, AND A SCORE OF 10 MEANS THAT ALL OF THE ACTIVITIES IN WHICH YOU WOULD NORMALLY BE INVOLVED HAVE BEEN TOTALLY DISRUPTED OR PREVENTED BY YOUR HEALTH CONDITION (AOM AND/OR SYMTOMS)

1. **FAMILY/HOME RESPONSIBILITIES:** ACTIVITIES RELATED TO THE HOME OR FAMILY INCLUDING CHORES AND DUTIES PERFORMED AROUND THE HOUSE (YARD WORK, DOING CHORES, ERRANDS, FAVORS FOR OTHER FAMILY MEMBERS, DRIVING CHILDREN TO SCHOOL, ETC.) _____

2. **RECREATION:** HOBBIES, SPORTS, AND OTHER SIMILAR LEISURE TIME ACTIVITIES _____

3. **SOCIAL ACTIVITY:** ACTIVITIES WHICH INVOLVE PARTICIPATION WITH FRIENDS AND AQUAINTANCES OTHER THAN FAMILY MEMBERS INCLUDING PARTIES, THEATRE, CONCERTS, DINING OUT, AND OTHER SOCIAL FUNCTIONS _____

4. **OCCUPATION:** ACTIVITIES THAT ARE A PART OF OR DIRECTLY RELATED TO ONE'S JOB INCLUDING NONPAYING JOBS AS WELL, SUCH AS HOMEMAKER OR VOLUNTEER WORKER _____

5. **SELF CARE:** ACTIVITIES WHICH INVOLVE PERSONAL MAINTENANCE AND INDEPENDENT DAILY LIVING (TAKING A SHOWER, DRIVING, GETTING DRESSED, ETC.) _____

6. **LIFE SUPPORT ACTIVITIES:** BASIC LIFE SUPPORTING BEHAVIORS SUCH AS EATING, SLEEPING, AND BREATHING _____

METHOD OF PAYMENT FOR TODAY'S CHARGES ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ _____

NOTICE: NOT ALL PATIENT'S REQUIRE X-RAYS TO FETERMINE TYPE PF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED
2. THE FEE PAID FOR X-RAYS IS FOR ANALYSIS ONLY. WE ARE REQUIRED TO MAINTAIN YOUR ORIGINAL X-RAYS. FILMS MAY BE LOANED TO ANOTHER HEALTH PROVIDER WITH YOUR PRIOR AUTHORIZATION ONLY.

PATIENT SIGNATURE_____ DATE_____

PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW. ALSO DESCRIBE THE TYPE AND FREQUECNY OF YOUR PAIN. FOR EXAMPLE: DULL, SHARP, CONSTANT, OFF AND ON, WHEN STANDING, SITTING, WORKING, ETC.

COMPLETE THESE DIAGRAMS