



Al Jameson, D.C.

Patient Information & History

Date: _____

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PATIENT INFORMATION

Name: _____

(First) (Initial) (Last) (Name called by)

Address: _____

Birthday: _____ Age: ____ Male Female

Social Security # ____/____/____

Occupation: _____

Employer: _____

Parents Name(if a minor): _____

Single Married Divorced Widowed Separated

Spouse's Name: _____

of Children: ____ Name(s) _____

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INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance company _____

Insurance ID number _____

Group / Claim number _____

Is patient covered by additional insurance? Yes No

Insurance company _____

Subscriber # and name _____

Birthdate _____ Group # _____

Please present insurance card(s) so we can put a copy in your file.

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CONTACT INFORMATION

Home phone _____

Cell phone _____

Work Phone _____ Ext _____

Email _____

Best way to reach you Home Cell Work Email

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell _____

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ACCIDENT INFORMATION

Is your condition due to an accident? No Yes Date: _____

Type of accident? Automobile Work Home Other

To whom have you reported the accident?

Insurance Worker's Comp Employer Other _____

Attorney Name (If applicable) _____

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PATIENT CONDITION

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes No

Is this problem: constant comes and goes

How does it Feel? Burning Sharp Shooting Dull Aching Stiff

Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

What makes your condition better? _____

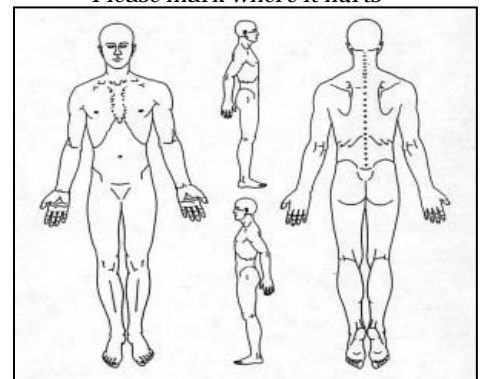
What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/movements that are painful to perform:

Sitting Standing Walking Bending Lying down Driving Reading Getting Up A

Please mark where it hurts



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HEALTH HISTORY

What other treatments have you had for this condition?

Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery

Name of other doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

Previous Chiropractic care? No Yes Date _____ Local Out of state _____

Date of Last: Physical Exam _____ Spinal x-ray _____ MRI _____

Spinal Exam _____ Dental x-ray _____ CT- Scan _____

List any Medications you are taking _____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant Yes No Beginning of last menstrual cycle _____

Check any of the following conditions you have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Headaches - Migraine | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus infection |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Vertigo/Dizziness |

STRESSORS

Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/ Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

EXERCISE

None
 Moderate
 Daily
 Heavy

Have you had any:	Description	Date
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

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AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Al Jameson, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

 Signature Date Parent (if patient is a minor)