

Patient's Name: _____

Date Problem Began: _____

A. Current Problem:

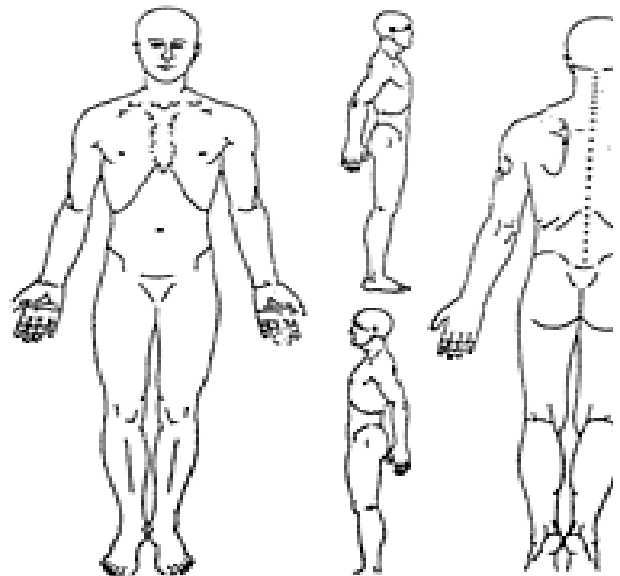
1. Explain what happened: _____
2. Is the pain area: Headache Neck Low-back Mid-back Other: _____
3. Is this related to: Work Auto Accident N/A
4. Does pain wake you while sleeping? Y N
5. Are you losing weight without trying? Y N
6. Are you coughing up blood or noticing it in stools or urine? Y N
7. Have you noticed any changes in moles or lumps? Y N
8. Do you have indigestion, difficulty swallowing, or chronic hoarseness? Y N
9. Have you been treated by a Medical Physician for this condition? Y N If Y, Name: _____
10. Have you ever been treated by a Chiropractor before? Y N If Y, Name: _____

11. MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:

12. Current Complaint: How do you feel today?
 0 1 2 3 4 5 6 7 8 9 10
 (No Pain) (Unbearable Pain)

13. How often are your symptoms present?
 0-25% 26-50% 51-75% 76-100%
 (Intermittent) (Constant)

14. In the past week, how much has your pain interfered with your daily activities? (e.g., work, social activities, household chores, etc...)
 0 1 2 3 4 5 6 7 8 9 10
 (No Interference) (Unable to carry on any activities)



B. Health History:

1. Are you taking any of the following medications? Insulin Tranquilizers Stimulants Nerve Pill
 Pains Killers (inc. Aspirin) Muscle Relaxers Blood Thinners Other(s): _____
2. Do you have, or ever had, any of the following diseases or conditions?

Y N Stroke	Date: _____	Y N Recent Fever	Y N Artificial Bones/Joints
Y N Heart Condition:	_____	Y N HIV+/ AIDS	Y N Lower Back Problems
Y N Corticosteroid Use (cortisone, prednisone, etc)	_____	Y N Cancer/Tumor	Y N Frequent Neck Pain
Y N Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss		Y N Anemia	Y N Arthritis/Osteoporosis
Y N Numbness in Groin/Buttocks		Y N Urinary Problems	Y N Diabetes/Tuberculosis
Y N Marked Morning Pain/Stiffness		Y N Visual Disturbances	Y N High/Low Blood Press
Y N Severe/Frequent Headaches		Y N Asthma	Y N Alcohol/Drug Abuse
Y N Fainting/Seizures/Epilepsy/Dizziness		Y N Prostate Problems	Y N Menstrual Problems
Y N Currently Pregnant, # of Weeks:	_____		
3. Do you smoke? Y N How much a day? _____ For how long? _____
4. Please list any other serious medical condition(s) you have or ever had: _____
5. Please list anything that you may be allergic to: _____
6. List previous surgeries/treatments & dates: _____
7. Your Family Health History: Cancer High Blood Pressure Diabetes
 Rheumatoid Arthritis Heart Problems/Stroke Allergies

8. Do you have children? **Y N** How Many? _____

Patient's Name: _____ Today's Date: _____
 Last First MI

A. About You: What you Prefer to be Called: _____

1. Birth date: _____ Male Female SS#: _____

2. Status: Minor Single Married/DP Divorced Separated Widowed

3. Occupation Status: Employed Retired Un-Employed FT Student PT Student

4. Mailing Address: _____
 Street City State Zip

5. Home Phone: _____ Work Phone: _____ Cell Phone: _____

6. Email Address: _____ Referred By: _____

7. Employer: _____ How Long? _____

8. Employer Address: _____
 Street City State Zip

B. Emergency Contact Info: (In the Event of Emergency)

1. Who should we contact? _____ Relation: _____

2. Home Phone: _____ Work Phone: _____ Cell Phone: _____

3. Who is your Primary Care Physician?: _____ Phone: _____

C. Insurance Information: (If you are NOT the PRIMARY insurance holder)

1. Insured's Name: _____ SS#: _____ Birth date: _____

2. Relationship to Insured: Spouse/DP Child

3. Insured's Address: _____
 Street City State Zip

D. INFORMED CONSENT: CHIROPRACTIC ADJUSTMENTS & CARE

I hereby request and consent to the performing of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or the patient named above, for whom I am legally responsible) by Dr. Jacques-Maynes.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to sprains, disc injuries, strokes, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustment and procedures. I understand that the doctor will perform an exam in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore with to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon facts known, is in my best interest.

I have read, or have had it read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the procedures and treatments.

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered
 (Initial) understand I am solely responsible for any balance not paid by my insurance company (if offered at this office)

I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

Patient's/Guardian's Signature: _____ Date: _____