For Office Use Only

Bilateral Weight Scales
R_____L_____

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____ Home Phone:_____ Cell: _____

Address: _____ City:_____ State:_____ Zip:_____

Occupation: _____Employer:_____Phone:_____

Birth Date: _____ Age: _____ Sex: M F Marital Status: S M W D

Spouse's Name: _____ # of Children: _____

How were you referred to our office?_____

Have you ever been to a Chiropractor before? _____ If yes, list names of doctors _____

List your chief complaints in the order of their severity:

1._____ For how long? _____

2._____ For how long _____

3._____ For how long? _____

Females: Are you pregnant? Yes__ O __ No__ O __ Not sure__ O __

Please list any conditions/medications_____

_____

_____

The vast majority of our patients have been involved in dozens of impacts which could cause **VERTEBRAL SUBLUXATION**. In order for Dr. Lee to better understand your case, please list at least five of yours.

1. When was your MOST recent **Auto/Motorcycle Accident**? Date: _____
   (Please circle) Front Back Side Other _____
   Any treatment received? Yes O No O
   If yes, what type of care?_____
   Chiropractic care? Yes O No O

2. When was the one before that? Date: _____
   (Please circle) Front Back Side Other _____
   Any treatment received? Yes O No O
   If yes, what type of care?_____
   Chiropractic care? Yes O No O

Most people have a slip, strain, twist, or fall playing **sports**, at **home** or **work**, whether it was reported or not.

1. When was your most recent stress or strain? Date: _____
   Any treatment received? Yes ___ No ___
   Chiropractic care? Yes ___ No ____
   If yes, what type of care?_____

2. The one before that? Date: _____
   Any treatment received? Yes ___ No ___
   If yes, what type of care?_____
   Chiropractic care? Yes ___ No ____

Please list any **other important traumas** (childhood traumas, illnesses, fractures, sprains, or surgeries) not mentioned:

1. Date: _____ Briefly describe the trauma _____
   Any treatment received? Yes ____ No ____ Chiropractic care? Yes ____ No ____

2. Date: _____ Briefly describe the trauma _____
   Any treatment received? Yes ____ No ____ Chiropractic care? Yes ____ No ____

ALL CHARGES ARE TO BE PAID WHEN SERVICES ARE RENDERED

I understand and agree that health insurance policies are an arrangement between an insurance carrier and me. I understand this office will prepare any necessary reports and forms to assist me in making a claim with my insurance company.

I am advising this office that this is not an accident claim (motor vehicle, personal or work injury), and agree that all services rendered will be charged directly to me making me personally responsible for payment.

I understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect on this account.

The initial fee paid for x-rays taken is for *analysis only*. The x-rays will remain property of this office. *Release of x-ray copies may be requested for a fee of $150.00 along with a written request from your physician*.

This office *does not* participate in the Medicare program.

Patient Signature:_____ Date:_____

Guardian or Spouse's Signature for Authorized Care:_____
PRINT NAME SIGNATURE

In case of emergency notify: _____ Phone No.: _____
Address: _____

Name of nearest relative: _____ Phone No.: _____
Address: _____

Revised 08/12