You HAVE / HAVE NOT previously had same/similar complaints. When? Month__________________ Year______________

Treatment for these complaints : MEDICATION CHIROPRACTIC CARE PHYSICAL THERAPY SURGERY NONE

OTHER ____

Have you lost time from work due to this injury? YES / NO Dates: ____

Are you able to perform your normal activities? List things you can't do ___________________________________

____

Name of your attorney___________________________ City of__________________Phone (   )________________

Other Injuries

Month_________Day______Year_______Body part injured___________________________________ Treated? YES NO

Month_________Day______Year_______Body part injured ___________________________________ Treated? YES NO

Month_________Day______Year_______Body part injured___________________________________ Treated? YES NO

I have never had any other injuries________.

Insurance Information

Name of Insured_________________________________Relationship to patient_____________________________

Name of insurance co. ______________________________Address :Street_________________________________

City, State, Zip__________________________________Claim No: _______________Contact__________________

Other vehicle insurance carrier__________________________________City of_____________________________

Claim No. (if known)__________________________________

My health insurance carrier__________________________________City of_____________________________

PLEASE GIVE YOUR INSURANCE CARDS / CERTIFICATE TO THE FRONT DESK FOR COPYING
PLEASE GIVE YOUR DRIVERS LICENSE TO THE FRONT DESK FOR COPYING

We are happy to provide insurance billing for you as part of our service at no charge to you. However, your insurance is a contract between *you* and *your carrier*. You are ultimately responsible for all charges incurred at this office. Please sign below, acknowledging your responsibility.

____

SIGNATURE DATE

OUR MISSION IS TO PROVIDE

CAREFULLY CONSIDERED DIAGNOSIS

GENTLY ADMINISTERED TREATMENT

THE CARE YOU NEED, NO MORE, NO LESS

REFERRAL TO OTHER PRACTITIONERS WHEN APPROPRIATE

HONEST AND UP TO DATE RECORD KEEPING .... IN SHORT

TO TREAT YOU THE WAY WE WOULD LIKE TO BE TREATED IF WE WERE THE PATIENT.