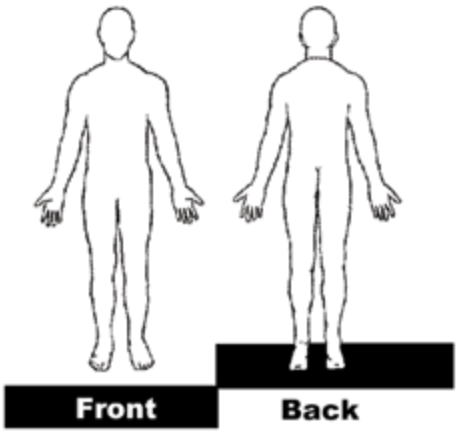
Campbell Chiropractic

Patient:_____ Date:_____

Address:_____
Street City State Zip
Phone:_____ Alternate Phone:_____ Email:_____
Sex: ☐ M ☐ F Age:_____ Birthdate:_____ Social Security #:_____
Emergency Contact:_____
Name Relationship Phone
Insurance Company:_____
Group #:_____ ID #:_____
Subscriber Name:_____ Subscriber Birthdate:_____
Subscriber Signature:_____ Date:_____
Relationship to Patient:_____ Date:_____

Is this condition due to an accident? ☐ No ☐ Yes Date ___ Type of accident? ☐ Auto ☐ Work ☐ Other
Was the accident reported? ☐ No ☐ Yes If yes, to whom? _____

Reason for visit:_____
When did your symptoms appear?_____
Is this condition getting progressively worse? _____
_____
Have you already received treatment for this condition? ☐ No ☐ Yes
If yes, explain:_____
_____
_____
_____



Mark an X on the picture where you have pain, numbness or tingling.
Rate the severity of your pain: 1 (least pain) to 10 (severe pain)

1 2 3 4 5 6 7 8 9 10

Type of pain: ☐ Sharp ☐ Dull ☐ Tingling ☐ Throbbing ☐ Stiff ☐ Cramps
☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Swelling ☐ Other

How often do you have this pain?_____
Is it constant or intermittent? _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Activities
Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying

Date of last: Physical Exam_____Blood Test_____Spinal Exam_____
Spinal X-Ray_____Chest X-Ray_____Urine Test_____MRI, CT, or Bone Scan_____

What is your exercise level? ☐ None ☐ Moderate ☐ Daily ☐ Heavy
What is your work activity? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor
What are your habits? ☐ Smoking Packs/Day ____ ☐ Alcohol Drinks/Day___☐ Coffee/Caffeine Cups/Day__

Are you pregnant? ☐ No ☐ Yes Due Date _____

Please **circle** if you have now or have ever had any of the following conditions.

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Bleeding Disorders	Breast Lump
Bronchitis	Bulimia	Cancer	Cataracts	Chemical Dependency
Chicken Pox	Diabetes	Emphysema	Epilepsy	Fractures
Glaucoma	Goiter	Gonorrhea	Gout	Heart Disease
Hepatitis	Hernia	Herniated Disk	Herpes	High Cholesterol
Kidney Disease	Liver Disease	Measles	Miscarriage	Mononucleosis
Multiple Sclerosis	Mumps	Osteoporosis	Pacemaker	Parkinson's Disease
Pneumonia	Polio	Prostate Problems	Prosthesis	Psychiatric Care
Rheumatoid Arthritis	Rheumatic Fever	Scarlet Fever	Stroke	Suicide Attempt
Thyroid Problems	Tonsillitis	Tuberculosis	Tumors, Growth	Typhoid Fever
Ulcers	Vaginal Infections	Venereal Disease	Whooping Cough	Other:_____

Have you had any surgeries? ☐ No ☐ Yes explain: _____

Have you had any broken bones or dislocations? ☐ No ☐ Yes explain: _____

Have you had any head injuries? ☐ No ☐ Yes explain: _____

Please describe any medications or vitamin supplements you are currently taking: _____

Patient certifies that all of the above information is true to the best of my knowledge. Patient hereby promises and agrees to pay Campbell Chiropractic for the full value for all goods and services provided to the Patient by Campbell Chiropractic. Patient agrees and consents to pay and reimburse Campbell Chiropractic all damages or expenses, incurred by as a result of the Patient's failure to make such required payments, including any and all collection fees, attorney's fees, court costs and other legal expenses. Patient hereby authorizes Campbell Chiropractic to release all information necessary to secure the payment of benefits. Patient authorizes the use of this signature on all insurance submissions.

Patient Name: _____ Date: _____

Legal Guardian Name and Relationship to Patient: _____ Date: _____

Patient or Legal Guardian Signature: _____ Date: _____