# Welcome to Naber Chiropractic

**"NATURAL HEALTH THROUGH CHIROPRACTIC"**

## Patient Information

Thank you for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date_____ S/S_____
First MI Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male

Birth date _____ Home phone # _____ Work phone # _____

Are you: Minor / Married / Divorced / Widowed / Single / Separated

E-mail address _____

Your employer _____ Occupation _____

Business Address _____ City_____ State ____ Zip _____

Spouse's or Parent's Name _____Workplace _____ Work phone # _____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____ Phone #_____

## Responsible Party

Name of person responsible for this account _____ S/S_____

Relationship to patient _____Phone # _____

Address _____ City _____ State ___ Zip _____

Name of employer _____Work phone # _____

## Financial & Insurance Information ( ***Please present Insurance Card!***)

Name of insured _____ Relationship to patient_____

Birth date _____Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone # _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State ___ Zip _____

How much is your deductible? _____How much have you used? _____ Max, Annual Benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? O No O Yes If YES, please complete the following:

Name of insured _____Relationship to patient _____

Birth date _____ Social Security #_____ Date employed _____

Name of employer_____ Work phone #_____

Address _____City _____ State ___ Zip _____

Insurance Co. _____ Phone _____ __ Group # _____ Employer# _____

Insurance Co. Address_____ City _____State _____Zip _____

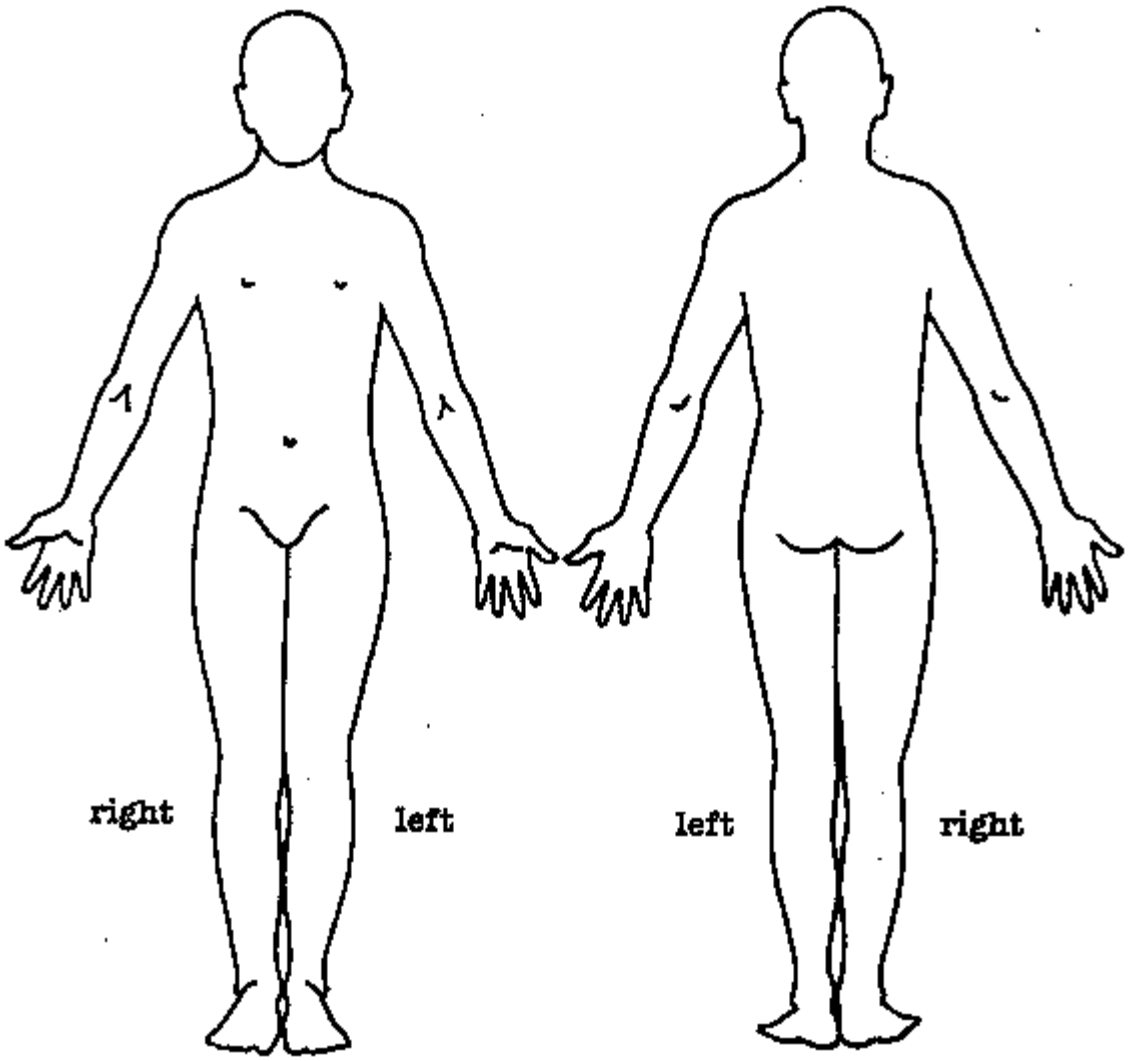
How much is your deductible? _____How much have you used? _____ Max. Annual Benefit?_____

**PAIN CHART**

SHOW AREA(S) OF PAIN OR UNUSUAL SENSATION

1. Mark the areas on this body where you feel the described sensations.
2. Use the appropriate symbols.
3. Mark areas of radiation of pain or sensation.
4. Include all affected areas.

| NUMBNESS | PINS & NEEDLES | BURNING | ACHING | STABBING |
|---|---|---|---|---|
| --------- | 00000000 | xxxxxxx | ****** | ////////// |
| --------- | 00000000 | xxxxxxx | ****** | ////////// |




**SUBJECTIVE COMPLAINT PAIN SCALE**

INTENSITY

Indicate intensity of pain on a scale of 1 through 10. 1 is least and 10 is most.

Borg Scale: 0 = Normal
1-3 = Low pain
4-6 = Moderate pain
7-9 = Intense pain
10 = Emergency

INTENSITY = _____

FREQUENCY

Indicate frequency of pain on a scale of 1 through 10. 1 is least and 10 is most.

10% of the time = 1 60% of the time = 6
20% of the time = 2 70% of the time = 7
30% of the time = 3 80% of the time = 8
40% of the time = 4 90% of the time = 9
50% of the time = 5 100% of the time = 10

FREQUENCY = _____

**C O N F I D E N T I A L**

## SYMPTOMS

Reason for visit _____ When did you first notice the symptoms?_____
Is this condition getting progressively worse? _____
Where specifically is the problem(s) located? _____
Which activities are difficult to perform? □ Sitting □ Standing □ Walking □ Bending □ Lying down
□ Other _____
Type of pain: □Sharp □Dull □Throbbing □Numbness □Aching
□Shooting □Burning □Tingling □Cramps □Stiffness
□Swelling □Other _____
Rate the severity of your pain. ( 1 mild pain or discomfort, to 10 severe pain ): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What treatment have you already received for your condition?
□Medication □Surgery □Physical Therapy □Other_____
Name and address of other doctor(s) who have treated you for your condition:
_____

## HEALTH HISTORY

***Check only those conditions which are applicable:***

| | | | |
|---|---|---|---|
| □Cancer | □Epilepsy | □Digestive Problems | □Tuberculosis |
| □Dizziness | □Numbness | □Hypertension | □Convulsions |
| □Tingling | □Diabetes | □Concussion | □Anemia |
| □Arthritis | □Allergies | □Back Problems | □Migraine |
| □Heart Attack | □Sinus History | □Rheumatic/Scarlet Fever | □Polio |
| □Venereal Disease | □Asthma | □Multiple Sclerosis | □Neuritis |
| □Hepatitis | □Muscular Dystrophy | □Rheumatism | □Psoriasis |
| □Eating Disorder | □Depression | □Fractures | □Emphysema |
| □Gout | □Osteoporosis | □Stroke | □Thyroid Problems |
| □Liver Disease | □Kidney Disease | □High Cholesterol | □Pacemaker |

Dates of last exams _____
( Women ) are you pregnant? **Yes No** Nursing? **Yes No** Taking birth control? **Yes No**
List any surgeries that you have had, and the dates that they occurred: _____
_____
Please list all medications you are currently taking: _____
Allergies: _____

## PRESENT COMPLAINTS

| | | | |
|---|---|---|---|
| □Headache | □Neck Pain/Stiff | □Chest Pain | □Nausea |
| □Concentration Loss | □Neck Motion Restricted | □Short of Breath | □Vomiting |
| □Memory Loss | □Upper Back Pain | □Irritable | □Cold Hands/Feet |
| □Dizziness | □Mid Back Pain/Stiff | □Numbness | □Anxiety |
| □Ringing in Ears | □Low Back Pain/Stiff | □Depression | □Insomnia |
| □Loss of Balance | □Right/Left Shoulder Pain | □Fatigue | □Neuritis |
| □Loss of Smell | □Right/Left Arm Pain | □Digestive Trouble | □Broken Bones |
| □Loss of Taste | □Right/Left Leg Pain | □Fainting | □Neuritis |
| □Sinus Trouble | □Pins & Needles Arms/Legs | □Nervousness | □Swelling |
| □Pain Behind Eyes | □Loss of Consciousness | □Eyes Sensitive/Light | Bruising |

| | | | |
|---|---|---|---|
| □Radiation of Pain Into: | □Right Arm | □Left Arm | □Both |
| | □Right Leg | □Left Leg | □Both |

**Daily Habits**

What types of exercise do you perform on a daily basis ? □None □Light □Moderate □Heavy

What do your daily work habits include? ( Ex: sitting, light labor, heavy labor, computer )

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? □No □Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

How much water do you take in daily? _____

**Accident Section (complete if due to accident)**

Type of accident □Auto □Worker's Comp □Fall □Other _____

Date of accident: _____ Accident location: _____

Describe accident: _____

What if any emergency treatment was given? _____

IF AUTO ACCIDENT COMPLETE BELOW

Did vehicle have seatbelts? □Yes □No

Were seatbelts worn? □Yes □No

List (seat) position in vehicle: _____

If vehicle had headrests, describe the position compared to your head

□Top of headrest aligned with top of head

□Top of headrest aligned with middle of head

□Top of headrest aligned with bottom of head

Briefly describe the impact collision,

□Head on collision □Left side impact □Right side impact □Rear end collision

List any parts of your body that made contact with vehicle parts: _____

_____

Were you braced for impact? □Yes □No

Were the brakes applied? □Yes □No

Were you looking up into inside rear view mirror? □Yes □No

Were you looking at outside door mirror? □Yes □No

Was your car stopped? □Yes □No

Any previous motor vehicle accidents? □Yes □No Describe: _____

_____

_____

**Authorization**

I certify that I have read and understand the above information to the best of my knowledge. The above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my chiropractor to release my information including the diagnosis and the records of any treatment or examination rendered to my dependents or me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance to pay directly to the chiropractor the chiropractic group insurance benefit otherwise payable to me. If prior authorization is needed and it is not obtained, I will agree to full responsibility of the bill for services rendered. I agree to settle the account in full within 25 days. If I fail to settle the account within 25 days I agree to a service charge of 1.3% monthly to be added to my account until it is paid in full. I agree to be responsible for payment of all services rendered to my dependents or me.

**X_____**

**SIGNATURE OF PATIENT (or parent/guardian if a minor)**