



HealthRite

Welcome

Patient Information

Date: _____

Patient: _____

Address: _____

City _____ State _____ Zip _____

Home: _____

Work: _____

Best time and place to reach you:

Sex: () M () F

Age: _____

Birthdate: _____

() Single () Married () Widowed () Separated
() Divorced

Patient Social Security Number (SS#):

Occupation: _____

Employer: _____

Employer

Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____ (SS#) _____

Occupation: _____

Spouse's Employer: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Number: _____

Whom may we thank for referring you?

Insurance:

Who is responsible for this account?

Relationship to patient: _____

Insurance Co.: _____

Group#: _____

Is patient covered by additional insurance?

() Yes () No

Subscriber's

Name: _____

Birthdate: _____ (SS#) _____

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ an assign directly to my Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship _____

Date _____

Accident Information:

Is condition due to an accident? () Yes () No

Date: _____

Type of accident () Auto () Work () Home

() Other

To whom have you made a report of your accident :

() Auto Insurance () Employer

() Worker Comp. () Other

Attorney Name (if applicable):

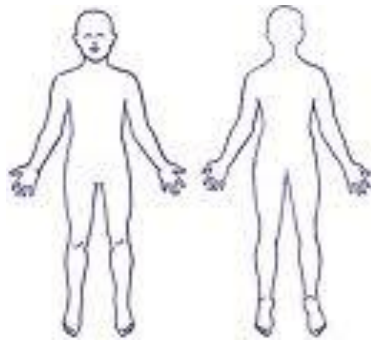


PATIENT CONDITION

When did your symptoms appear?

Is this condition getting progressively worse? () yes () no () unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain):

Type of pain:

- () sharp () dull () throbbing () numbness () aching () shooting
- () burning () tingling () cramps () stiffness () swelling ()

Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your () work () sleep () daily routine () recreation

Activities or movements that is painful to perform:

- () sitting () standing () walking () bending () lying down



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HEALTH HISTORY

What treatment have you already received for your condition? () Medications () Surgery () Physical Therapy
Chiropractic Services () None () Other: _____

Name and address of other doctor(s) who have treated you for your condition: _____

Date of last: Physical Exam _____ Spinal X- Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental x-Ray _____ MRI,CT-Scan, Bone Scan _____

Circle to indicate if you have had any of the following if **NOT** leave it blank:

- | | | |
|--------------------|---------------------|--------------------|
| AIDS/HIV | Chemical Dependency | Pneumonia |
| Alcoholism | Chicken Pox | Polio |
| Liver Disease | Prostate Problems | Rheumatic Fever |
| Allergy Shots | Diabetes | Psychiatric Care |
| Emphysema | Prosthesis | Mononucleosis |
| Measles | Epilepsy | Goiter |
| Anemia | Fractures | Scarlet Fever |
| Anorexia | Migraine/Headache | Suicide Attempt |
| Appendicitis | Rheumatic Arthritis | Thyroid Problems |
| Gout | Miscarriage | Pacemaker |
| Arthritis | Glaucoma | Multiple Sclerosis |
| Bleeding Disorders | Gonorrhea | Stroke |
| Mumps | Hernia | |
| Heart Disease | Herpes | |
| Breast Lump | High Cholesterol | |
| Hepatitis | Osteoporosis | |
| Bronchitis | Ulcers | |
| Herniated Disk | Parkinson's Disease | |
| Bulimia | Vaginal Infections | |
| Cancer | Veneral Disease | |
| Cataracts | Kidney Disease | |
| | Tumors growths | |

Other(s): _____



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EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Daily
- Light Labor
- Heavy
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day: _____
 Drinks/Week: _____
 Cups/ Day: _____

Reason: _____

Are you pregnant? Yes No Due Date: _____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name: _____
 Pharmacy Phone: _____

Injuries/Surgeries you have had:	Description	Date
Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____
Surgeries:	_____	_____