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):

_____

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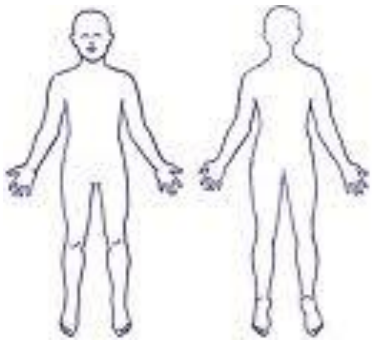
PATIENT CONDITION

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

Other(s):

_____

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EXERCISE	WORK ACTIVITY	HABITS
( ) None ( ) Moderate ( ) Daily ( ) Heavy	( ) Sitting ( ) Standing ( ) Daily ( ) Light Labor ( ) Heavy ( ) Heavy Labor	( ) Smoking ( ) Alcohol ( ) Coffee/Caffeine Drinks ( ) High Stress Level Reason: _____

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

Are you pregnant? ( ) Yes ( ) No Due Date:_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name: _____
Pharmacy Phone:_____

Injuries/Surgeries you have had: **Description** **Date**

Falls:_____
Head Injuries:_____
Broken Bones:_____
Dislocations:_____
Surgeries:_____