



Name: _____ Home Phone: _____

Street: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: ____ / ____ / ____ Social Security Number: _____

Employer: _____ Occupation: _____

Marital Status (Check) Single Married Widowed Separated Divorced How Many Children? _____

Spouse's Name: _____ Work Phone: _____

Employer: _____ Occupation: _____

Other Nearest Relative: _____ Phone: _____

List present complaints:

1. _____
2. _____
3. _____

Is this condition interfering with your:

Work Sleep Daily Routine Other _____

Have you seen any other Doctors for this condition? Yes No

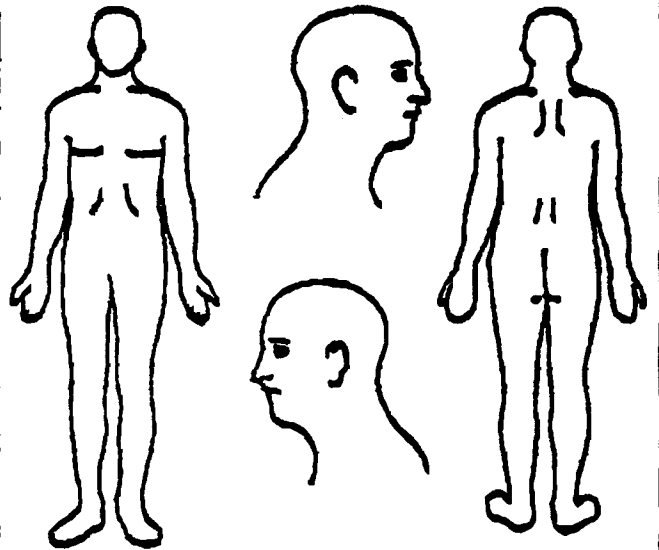
If Yes, Describe _____

List Surgical Operations & Years: _____

Family History of Health Problems: _____

List Current Medications: _____

Please mark your areas of pain on the figures below.



Referred by: Friend _____ Phone Book Sign Mailer Other _____

Insurance Company: _____

Type of Coverage: Group Health Worker's Comp Personal Injury (Auto Acc.) Other _____

If this is group health or major medical insurance, is this condition the result of an accidental injury? Yes No

If you are covered under your spouse, please give spouse's Social Security Number: _____ Date of Birth: ____ / ____ / ____

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Parent Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

AUTOMOBILE OR WORK INJURY QUESTIONNAIRE

Date of Accident: _____ Hour _____ AM PM Location: _____

How Did the Accident Occur? Auto Collision On-the-Job Injury Other: _____

Please Describe the Accident or Injury: _____

List the extent of the injuries as you know them: _____

Did you require Post-Accident Hospitalization? Yes No If yes, where? _____

Please describe: _____

Have you had similar accidents or injuries before? Yes No If yes, when? _____

Have you lost any days of work? Yes No If yes, dates _____

Insurance companies involved:

Company of person responsible for injuries: _____ Phone: _____

Address: _____ Adjuster _____

City _____ State _____ Zip _____ Claim # _____

Your Company: _____ Phone: _____

Address: _____ Adjuster _____

City _____ State _____ Zip _____ Claim # _____

Other Company(s): _____ Phone: _____

Address: _____ Adjuster _____

City _____ State _____ Zip _____ Claim # _____

Do you have an attorney that has advised you in this case? Yes No If yes, please give:

Attorney's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

COMPLETE THIS SECTION ONLY IF WORK INJURY

If Work Related, Did You Report The Injury To Your Foreman or Employer? Yes No

Name of the Foreman or Authorized Person _____ Phone # _____