

COLLARD CHIROPRACTIC & ACUPUNCTURE

PATIENT PERSONAL/ CONFIDENTIAL DATA

Patient: _____ Date: _____
Social Security No.: _____ - _____ - _____ Date of Birth: _____ Age: _____ Sex: M F
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Is it ok to text this phone? Y N
E-mail address _____ Marital Status: _____
Employer: _____ Address: _____
Name of Spouse _____ No. of Children: _____
Spouses Employer: _____ Address: _____

How did you learn of this clinic? _____
If referred who referred you? _____

Do you have insurance? Y N
Name of Insurance: _____

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

Signature Patient: _____ Signature Physician: _____
Date: _____ Date: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain ☐ Extremity pain
☐ Other: _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began: _____

Rate the pain: (please circle) no pain 1 2 3 4 5 6 7 8 9 10 worst pain

What makes the conditions worse? _____

What makes the conditions better? _____

Other Doctor seen for this condition: _____

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Please continue filling out this form on the reverse side.



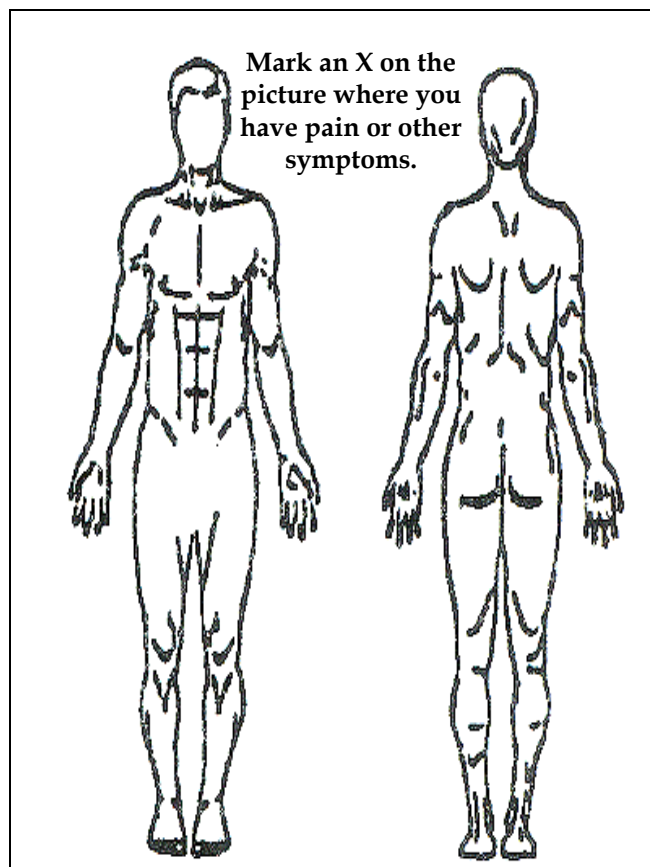
Patient: _____
Date: _____

Please Check all of the following that apply to

GENERAL HEALTH

- | | |
|---|---|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergy _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke (date) _____ |
| <input type="checkbox"/> Corticosteroid Use | <input type="checkbox"/> Cancer/Tumor _____ |
| <input type="checkbox"/> Taking Birth Control | <input type="checkbox"/> Abnormal Weight _____ |
| <input type="checkbox"/> Numbness in Groin/
Buttocks | <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pain unrelieved by
position or rest |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Currently Pregnant
#weeks _____ |
| <input type="checkbox"/> Prostate problems | |
| <input type="checkbox"/> Menstrual problems | |
| <input type="checkbox"/> Urinary problems | |
| <input type="checkbox"/> Pain at Night | |
| <input type="checkbox"/> Surgeries _____ | |

- ☐ Medications: _____
- ☐ Other Health Problems _____



Family History:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Heart Problems/Stroke

MUSCULO SKELETAL SYSTEM

- | | |
|---|--|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Spasms |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Ankle | |

NERVOUS SYSTEM

- | | |
|--|--|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Loss of feeling | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Headaches | |

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as His/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____ **Parent/ Guardian's Signa-**

Doctors Signature: _____ **Date:** _____

Dr. Chad Lynn Collard D.C.