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.

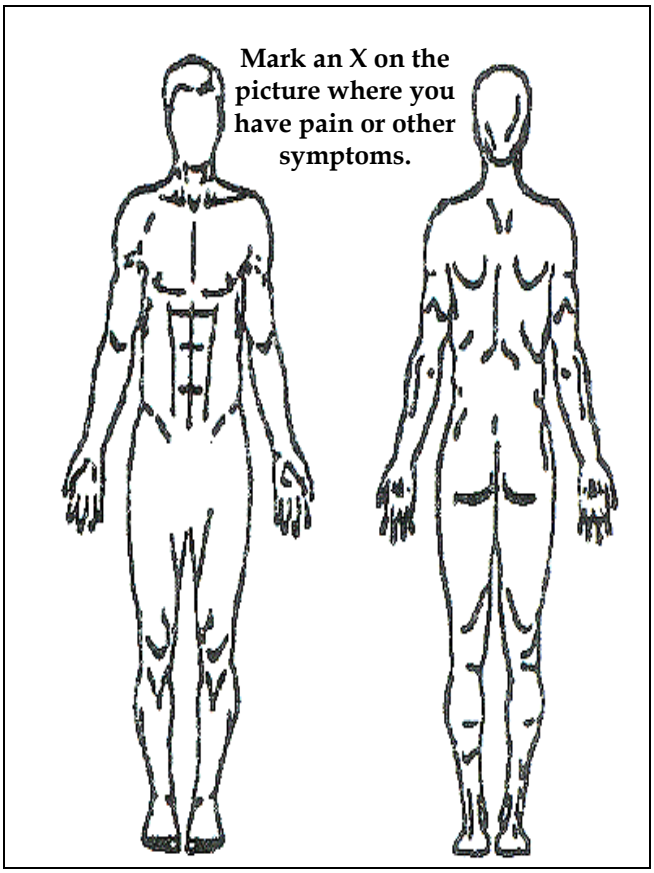
Signature Patient: _____ Signature Physician: _____
Date: _____ Date: _____

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%

Patient: _____
Date: _____



Please Check all of the following that apply to

GENERAL HEALTH

□ Recent Fever
□ Diabetes
□ High Blood Pressure
□ Corticosteroid Use
□ Taking Birth Control
□ Numbness in Groin/ Buttocks
□ Osteoporosis
□ Epilepsy/Seizures
□ Prostate problems
□ Menstrual problems
□ Urinary problems
□ Pain at Night

□ Sinus
□ Allergy _____
□ Stroke (date) _____
□ Cancer/Tumor _____
□ Abnormal Weight □Gain □Loss
□ Pain unrelieved by position or rest
□ Currently Pregnant #weeks_____

□ Surgeries _____
_____
□ Medications: _____
_____
□ Other Health Problems
_____

Family History:
□ Cancer
□ Rheumatoid Arthritis
□ Diabetes
□ Heart Problems/Stroke

MUSCULO SKELETAL SYSTEM

□ Low back pain
□ Mid back pain
□ Pain between shoulders
□ Neck pain
□ Knee
□ Ankle
□ Elbow
□ Wrist
□ Spasms
□ Shoulder pain
□ Jaw pain

NERVOUS SYSTEM

□ Numbness
□ Loss of feeling
□ Paralysis
□ Dizziness
□ Fainting
□ Headaches
□ Migraines
□ Forgetfulness
□ Confusion
□ Depression
□ Insomnia

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 Signature:_____

Doctors Signature: _____Date:_____

Dr. Chad Lynn Collard D.C.

9103 South 1300 West #101 West Jordan, Utah 84095 office 801.569-1141
www.collardchiropractic.com