

COOL SPRINGS BACK & NECK CARE

Welcome to our practice! Please take a few minutes to fill out this information. Return it to the receptionist when you are finished along with your driver's license & any insurance information.

Patient Name _____ Date _____
Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip _____

Home () _____ Cell () _____ Work () _____
If needed, may we contact you at any of these numbers?

E-mail _____

Sex M or F SS # _____ Age _____ Birthdate _____
Married Widowed Single Separated Divorced

Occupation _____ Patient Employer/School _____

Ages of your children _____ If Female, are you pregnant? _____ Due Date _____

Spouse's Name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Phone _____ Relationship _____

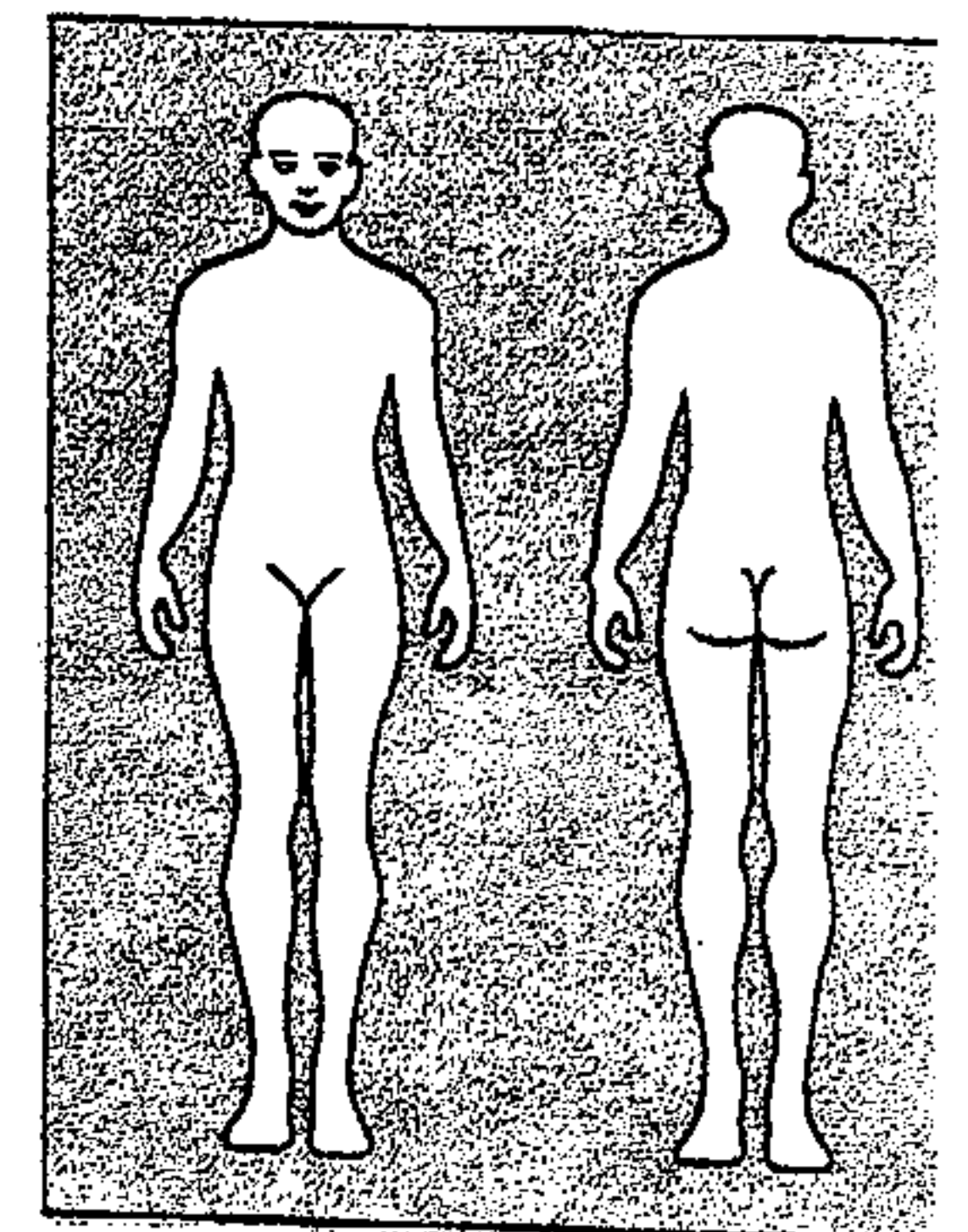
PATIENT CONDITION

Please list any symptoms you have _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture to the right 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 that are painful to perform Sitting Standing Walking Bending Lying Down

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.

Attorney Name (if applicable) _____

PLEASE TURN OVER TO FILL OUT THE BACK

COOL SPRINGS BACK & NECK CARE

HEALTH HISTORY

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

Date of Last: Chiropractic Adjustment _____ Spinal X-Ray _____
Spinal Exam _____ MRI, CT-Scan _____

Please list any significant Diagnosis, Surgeries, Injuries, etc. you've had.

CURRENT MEDICATIONS

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Cool Springs Back & Neck Care 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 authorize the use of my signature on all submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian, or Personal Representative

Date

Relationship to Patient