

PATIENT INFORMATION

Name _____ Birth date _____ Age _____
Address _____ Social Security # _____
City _____ State _____ Zip Code _____ Home Phone _____
Cell phone _____ Work phone _____ E-mail _____
Employer's Name _____ Position _____ Address _____
Marital status – *circle one* [S M W D] Are You Insured? [Y N] Ins. Company _____
Spouse's name _____ Are you Pregnant? [Y N] Number of children _____
Referred by _____

Have you had chiropractic care before? _____ **When?** _____

What is your current complaint? _____

Is this condition due to:

<input type="checkbox"/> Auto accident	<input type="checkbox"/> Work injury	Check any activities which aggravate your condition:	List all prescription drugs you now take:
<input type="checkbox"/> Other accident	<input type="checkbox"/> Illness	<input type="checkbox"/> Standing	_____
<input type="checkbox"/> Unknown cause		<input type="checkbox"/> Bending	_____
Date symptoms appeared		<input type="checkbox"/> Twisting	_____
_____		<input type="checkbox"/> Sitting	_____
		<input type="checkbox"/> Lying	
		<input type="checkbox"/> Coughing	
		<input type="checkbox"/> Walking	
		<input type="checkbox"/> Lifting	

Are symptoms:	Other doctors seen for other problems:	List all non- prescription drugs you now take:
<input type="checkbox"/> Improving	_____	_____
<input type="checkbox"/> About the same	_____	_____
<input type="checkbox"/> Getting worse	_____	_____
<input type="checkbox"/> Intermittent [come and go]	_____	_____

Have you had these symptoms Before?	List all previous accidents:	Check here if you
<input type="checkbox"/> No	_____	<input type="checkbox"/> smoke
<input type="checkbox"/> Yes When? _____	_____	<input type="checkbox"/> don't exercise regularly

Who is your general practitioner? Dr. _____	List all surgical operations:	Check here if you have a family history of :
_____	_____	<input type="checkbox"/> arthritis
_____	_____	<input type="checkbox"/> cardiovascular disease
_____	_____	<input type="checkbox"/> diabetes
_____	_____	<input type="checkbox"/> cancer

Would you like us to send a report to your general practitioner?
 Yes No

I understand and agree that medical insurance policies are an arrangement between my insurance company and myself - not my insurance company and this office. I authorize this office to release any medical information and complete any usual and customary reports and forms at no charge, to assist in collecting from my insurance company. However, I understand that I am ultimately responsible for payment in full and agree to pay a \$10 per month billing charge and a 1.5% monthly interest charge for all unpaid balances, which become 30 days past due. If necessary, I also agree to take full responsibility for all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt. 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.

I have read this financial policy. I understand and agree to all the terms of this policy.

Signature: _____ Date: _____
[Parent's signature if minor]

Please check the type of care desired so that we may be guided by your wishes when possible:
[] Temporary relief [] Control of immediate problem [] Total healthcare [] I prefer the Dr. to select the type of care he feels is best for me



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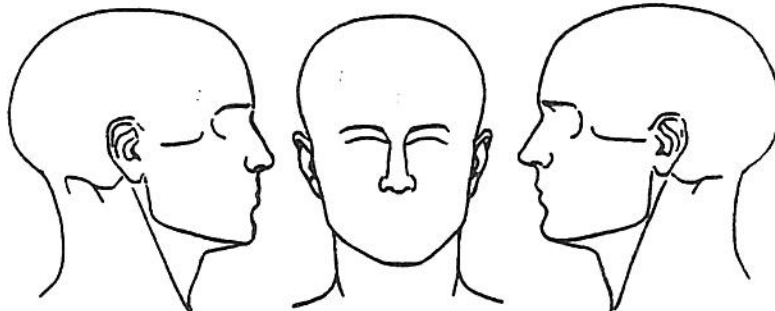
Patient Name: _____

(please print)

Date: _____

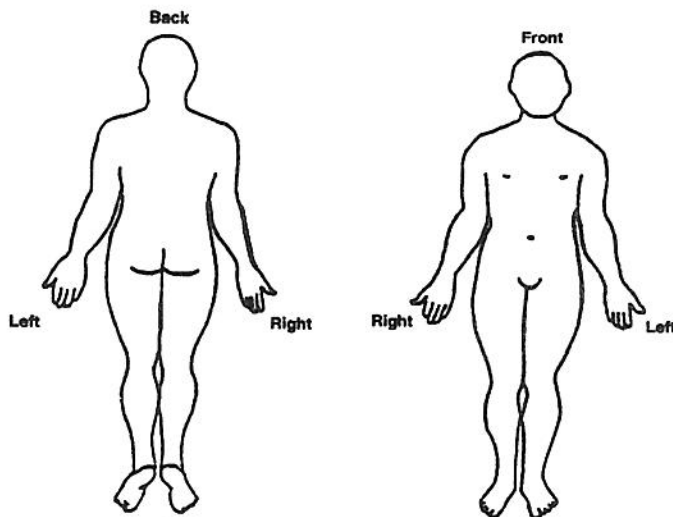
Please draw the location of your symptoms on the body diagram below and mark your current level of pain on the line at the bottom of the diagram.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^ ^^	=====	000000	//////	xxxxxx
^^^ ^^	=====	0000	////	xxx



No Pain |-----| Worst Pain Possible

Please make a slash through this line as to the level of your pain.



No Pain |-----| Worst Pain Possible

Please make a slash through this line as to the level of your pain.

Patient Signature: _____

Date: _____



Jamie M. Enos, D.C.

Email Newsletter Signup form

Please fill out the form below to be added to our email newsletter list.

Email address: _____

Full name: _____

By providing us with your email address on this form, you are signing up for our (weekly,bi-weekly,monthly) newsletter. Please note that you may unsubscribe at any time by utilizing the unsubscribe link provided in every newsletter.

Enos Chiropractic Center is committed to protecting your privacy. We will not share or sell your email address.