

Dr. Brian Roadhouse
Chiropractic Physician

NEW PATIENT INFORMATION

Name _____ Date _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birth Date _____ Age _____ Male Female

Marital Status: Married Single Divorced Widowed Number of Children _____

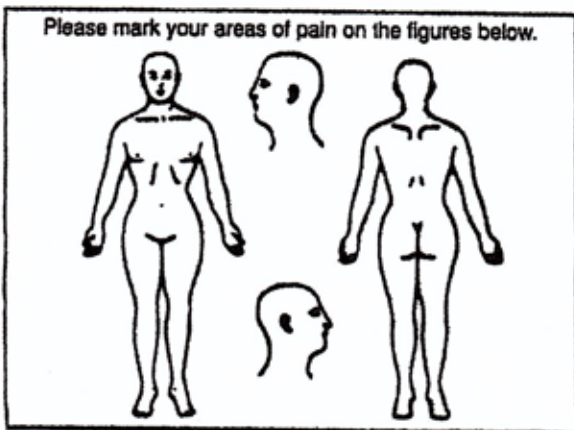
Occupation _____ Employer _____

Have You Had Chiropractic Care Before? Yes No If so, When? _____

Date Of Last Physical _____ Family Physician _____

List Your Chief Symptoms In Order Of Severity:

1. _____ For How Long? _____
2. _____ For How Long? _____
3. _____ For How Long? _____



What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying, etc.)

1. _____
2. _____
3. _____
4. _____

When did your symptoms start?

1. _____

Is this injury work related? Yes No Have you reported it to your employer? Yes No

Is this injury related to an automobile accident? Yes No

How frequent is the pain? Daily Constant Upon Activity Intermittent
 Other _____

How did it happen? _____

Describe the pain: Sharp Dull Ache Throbbing Tight Sore Pressure
 Other _____

What makes it worse? _____

What makes it better? _____

Is the pain worse in the: Morning Evening No Difference

Does the pain radiate to any other parts of your body? _____

What medications have you taken for this? _____

Other doctors seen for this condition _____

Have you had any previous treatment for this or similar conditions? No Yes

If yes explain _____

Have you ever been in an auto accident? Yes No

Please Describe _____

Have you ever had a Workers' Compensation Injury? Yes No When? _____

Is there a history of back problems in your family? Yes No Describe _____

Referred by: _____

FAMILY HISTORY

Name of Spouse _____ Occupation _____ Employer _____

Ages of Children _____ If Female are you pregnant? Yes No

Patient's Nearest Relative _____ Phone _____

Are you or have you ever been diagnosed with cancer? _____

Check Symptoms that apply:

- Headache
- Irritability
- Shortness of Breath
- Neck Pain
- Chest Pain
- Leg Pain
- Neck Stiffness
- Numbness/Tingling in Legs
- Head seems heavy
- Numbness in Toes
- Numbness/Tingling in Arms
- Dizziness
- Other _____

Other pertinent information: _____

Will we be filing this on your insurance? Yes No Insurance Company _____

Insurance ID _____ Group# _____

Secondary Insurance Company _____ ID# _____

INSURANCE INFORMATION

I understand and agree that health and accident policies are an arrangement between and 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 this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am 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 _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize Dr. Brian Roadhouse and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any part of my (Patient) record to any person or corporation which is or may be liable under a contract to the clinic, to the patient, 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.

Signature _____