

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 \_\_\_\_\_

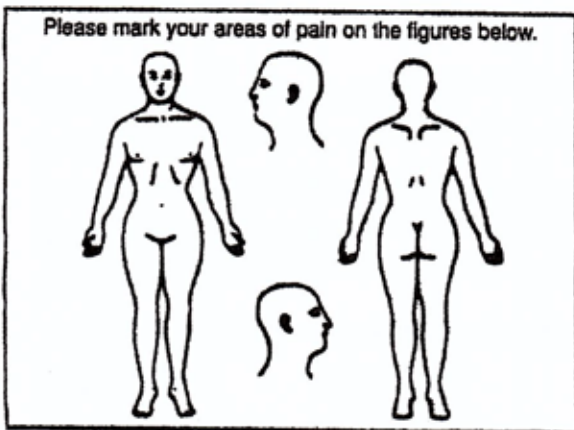
Occupation \_\_\_\_\_ Employer \_\_\_\_\_

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 \_\_\_\_\_