DEFINED Spine
CHIROPRACTIC + WELLNESS

PATIENT CONTACT INFORMATION

Appointment Date: _____/_____/_____

Patient Name (Last): _____ (First): _____ (MI): ____ Nickname: _____

Patient Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone Carrier (i.e. Verizon) _____ Occupation: _____

Birth date: _____ SS#: _____-_____-_____ Gender: M / F

Email: _____@_____

Emergency Contact: _____Phone #: (_____) _____-_____

Children (Names & Ages): _____

Family Physician (Name and Clinic Name): _____

PATIENT INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group#: _____

Insurance Phone: _____ Name of the Insured: _____

Cardholder's Birth Date: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Defined Spine Chiropractic & Wellness, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctors and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctors and clinic and to the extent permissible under the law to such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____/_____/_____

PATIENT SIGNATURE **DATE**

PRESENT HEALTH CONDITION

What is your goal in our office? _____

Do you have a health problem that you would like addressed? **YES / NO/ WELLNESS CARE**

Major Complaints: _____

When did it start? _____ How did it start? _____

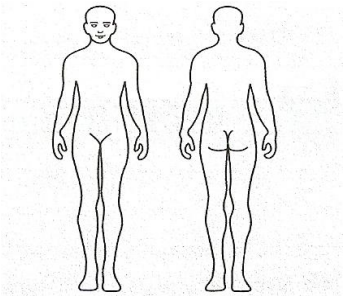
Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be responsible for? **YES / NO** Explain**:** _____

Have you seen anyone else for this? **YES / NO** Who and When: _____

Have you ever been to a chiropractor? **YES / NO** Who and When: _____

Does it radiate to any other part of your body? **YES / NO** Where: _____

MARK with an **X** on the diagram below where your pain is located:



CIRCLE your type(s) of Pain:

DULL / SHARP / BURNING / NUMBNESS / SORENESS
STIFFNESS / DEEP / SURFACE / OTHER: _____

Did it begin: **GRADUALLY / SUDDENLY**

CIRCLE your level of pain intensity: (1=mild, 10=intense)

1 2 3 4 5 6 7 8 9 10

Has your problem been getting: **WORSE / BETTER / SAME / OTHER: _____**

Is your pain **CONSTANT** / **COME AND GO**? Have you had anything like this before? **YES / NO**

What makes your symptoms better? _____

What makes your symptoms worse? _____

What have you tried to alleviate your symptoms? _____

Has your condition affected your daily activities? **YES / NO** Explain: _____

Women: Are you pregnant? **Yes/No** Trying to conceive? **Yes/No** Nursing? **Yes / No** Taking birth control pills? **Yes/No**

PAST HEALTH HISTORY

Have you ever been diagnosed with any other conditions? **YES / NO** What: _____

Have you ever had the problem that you are presenting with today? **YES / NO**

Other providers for this condition: **YES / NO** Who: _____ When:_____

Are you under another doctor's care presently for any type of health problem?_____

Have you ever had any past significant auto accidents/ work injuries or falls?_____

Are you currently taking any medication? If so, please list medication and reason for taking: _____

Have you ever undergone any type of surgery? **YES / NO What and when?** _____

Do you smoke, drink alcohol or use recreational drugs? How much and how often? _____

Do you have any allergies? _____

ADDITIONAL INFORMATION YOU WISH TO SHARE: _____

_____ / / _____
PATIENT'S SIGNATURE **DATE**

_____ / / _____
CASE MANAGER'S SIGNATURE **DATE**