

**WELCOME
TO
AUBURN CHIROPRACTIC ASSOCIATES**

PATIENT INFORMATION

Patient _____
Address _____

Sex _____ Age _____ Birthdate _____
Patient SS# _____
Are you a full-time student? _____
Occupation _____
Employer _____
Employer Address _____

Spouse's Name _____ Birthdate _____

Employer Name/Address _____

PHONE NUMBERS

Home _____ Work _____
Cell _____
Best time & place to reach you _____
Can we leave a message at the above
Telephone #'s? _____
Emergency Contact _____
Contact Number _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Please complete each line. If not applicable, please state so.

Primary Insurance _____ Contract # _____
Subscriber _____ Relationship _____
Subscriber's Birthdate _____ SS# _____
Subscriber's Address _____

Secondary Insurance _____ Contract # _____
Subscriber _____ Relationship _____
Subscriber's Birthdate _____ SS# _____
Subscriber's Address _____

Accident or Disability Policy _____
Contract # _____

ACCIDENT INFORMATION

Is condition due to an accident? _____ 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) _____
Automobile Insurance _____
Adjustor _____ Telephone # _____

ASSIGNMENT AND RELEASE

I the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Tracy L. Hartford, Auburn Chiropractic Associates, 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Date _____

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

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

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|--|---|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

EXERCISE

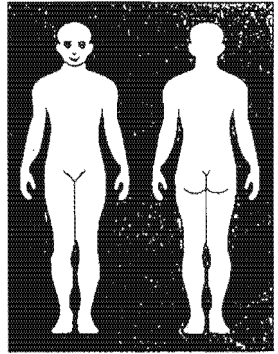
- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking _____ Packs/Day _____
- Alcohol _____ Drinks/Week _____
- Coffee/Caffeine Drinks _____ Cups/Day _____
- High Stress Level _____ Reason _____



Are you pregnant? Yes No Due Date _____

Please list any surgeries/injuries you have had.

Description	Date
_____	_____
_____	_____
_____	_____

Please list any medications, vitamins, herbs or minerals you are presently taking.

Please list any allergies you have.
