



New Patient's Form

Please fill out as much information as possible

Is your visit due to an accident ___Yes ___No

FIRST NAME: _____ LAST NAME: _____ DATE: _____

CURRENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE (CELL): _____ (HOME): _____ E-MAIL: _____

BIRTH DATE: _____ AGE: _____ SEX: _____ OCCUPATION: _____

EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATION: _____

HOW DID YOU HEAR ABOUT US? _____

FAMILY DOCTOR: _____ ADDRESS: _____ PHONE: _____

DATE LAST SEEN: _____ WHAT WERE YOU SEEN FOR: _____ OUTCOME: _____

REFERRING DOCTOR: _____ ADDRESS: _____ PHONE: _____

PRIMARY INSURANCE INFO:

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S DATE OF BIRTH: _____ NAME OF INSURANCE COMPANY: _____

IF IN AUTO ACCIDENT/WORK COMP. INJURY, PLEASE PROVIDE:

NAME OF INSURANCE COMPANY: _____ CONTACT PERSON: _____

PHONE NUMBER: _____ CLAIM NUMBER: _____ DATE OF ACCIDENT: _____

SECONDARY INSURANCE INFO (IF APPLICABLE):

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S DATE OF BIRTH: _____ NAME OF INSURANCE COMPANY: _____

RELEASE OF INFORMATION

I AUTHORIZE ELITE TOTAL REHAB AND ITS STAFF TO RELEASE TO THE ABOVE COMPANY(IES) OR ITS REPRESENTATIVES, TO MYSELF, TO MY PRIMARY CARE PHYSICIAN OR REFERRING PHYSICIAN ANY INFORMATION USED FOR TREATMENT AND PAYMENT.

ASSIGNMENT OF BENEFITS

I UNDERSTAND AND AGREE THAT HEALTH/ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME AND CHARGED ARE MY PERSONAL RESPONSIBILITY FOR TIMELY PAYMENT. I UNDERSTAND IF I TERMINATE MY CARE/TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

CONSENT TO TREATMENT

I _____ (PRINT NAME) KNOWING THAT I HAVE A CONDITION REQUIRING DIAGNOSIS AND TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO DIAGNOSTIC EXAMINATION PROCEDURES AND TREATMENT BY DR CURTIS OWEN

SIGNATURE: _____ DATE: _____

(SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN IF PATIENT IS UNDER 18)

DATE CURRENT SYMPTOMS BEGAN: _____

PLEASE GIVE A BRIEF DESCRIPTION OF HOW THE SYMPTOMS BEGAN:

HAVE YOU EVER HAD THE SAME CONDITION? YES NO IF YES, WHEN? _____

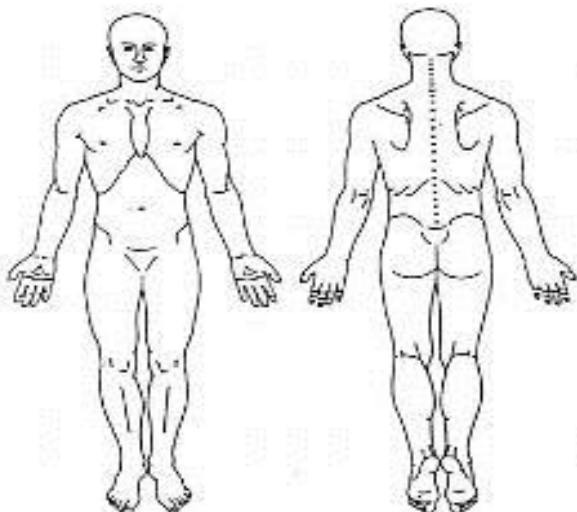
HAVE YOU SEEN ANY OTHER PRACTITIONERS FOR YOUR CURRENT COMPLAINT? YES NO

IF YES, WHO AND PLEASE DESCRIBE: _____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? YES NO

IF YES, PLEASE DESCRIBE/WHEN? _____

USE THE DIAGRAM BELOW TO INDICATE WHERE YOUR PAIN IS LOCATED:



USE SYMBOLS TO DESCRIBE YOUR PAIN:

- BURNING = B
- SHARP = SH
- NUMB = N
- DEEP/DULL ACHE = D
- PINS/NEEDLES = P
- STIFFNESS = ST
- OTHER (PLEASE SPECIFY):

CIRCLE THE NUMBER ON THE LINE BELOW INDICATING YOUR LEVEL OF PAIN:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS? _____

WHAT MAKES YOUR PROBLEM WORSE? _____

WHAT MAKES YOUR PROBLEM BETTER? _____

DOES THE PAIN RADIATE ANYWHERE? YES NO IF YES, WHERE TO? _____

DOES YOUR PROBLEM WAKE YOU UP AT NIGHT? YES NO

WHAT TIME OF DAY ARE YOUR SYMPTOMS WORSE (IE MORNING, AFTERNOON, ETC)? _____

HAS THIS PROBLEM INTERFERRED WITH YOUR WORK AND DAILY ACTIVITIES (CHECK ALL THE APPLY)?

NOT AT ALL A LITTLE MODERATELY QUITE A BIT EXTREMELY

PLEASE EXPLAIN: _____

DID YOU RECEIVE ANY DIAGNOSTIC IMAGING?

X-RAY MRI CT OTHER: _____

DATE TAKEN? _____

SIGNATURE: _____ DATE: _____

(SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN IF PATIENT IS UNDER 18)



PLEASE LIST ALL MEDICATIONS/VITAMINS/SUPPLEMENTS YOU CURRENTLY TAKE:

PLEASE LIST ALL REASONS YOU MAY HAVE BEEN HOSPITALIZED IN THE PAST:

PLEASE LIST ALL CURRENT AND PAST MEDICAL CONDITIONS:

PLEASE LIST ALL SURGICAL PROCEDURES AND MAJOR TRAUMA (IE, BROKEN BONES) YOU HAVE HAD:

PLEASE LIST ALL PAST AND PRESENT HEALTH CONDITIONS OF PRIMARY FAMILY MEMBERS (IE, HEART DISEASE, DIABETES, CANCER, ARTHRITIS, ALS, LUPUS):

DO YOU SMOKE? YES NO IF YES, HOW MANY CIGARETTES PER DAY? _____

HOW WOULD YOU DESCRIBE YOUR ALCOHOL INTAKE (CIRCLE ONE): NONE LIGHT MODERATE HEAVY

PLEASE CIRCLE ANY OF THE FOLLOWING IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE CONDITIONS LISTED (AND USE A "C" FOR A CURRENT PROBLEM AND A "P" FOR A PAST PROBLEM):

- | | | | |
|----------------------|------------------------|-------------------------|-----------------------|
| ALLERGIES | ANEMIA | ARTHRITIS | BACK PAIN |
| BREAST LUMP | CANCER | CHEST PAIN | DIFFICULTY BREATHING |
| HEADACHES | RHEUMATOID ARTHRITIS | HIGH BLOOD PRESSURE | STROKE |
| ANGINA | PROSTATE PROBLEMS | DIABETES | HIGH CHOLESTEROL |
| KIDNEY STONES | KIDNEY INFECTION | DIARRHEA/CONSTIPATION | HEMORRHOIDS |
| IRREGULAR HEART BEAT | PACEMAKER | DIGESTIVE PROBLEMS | NUMBNESS/TINGLING |
| ULCER | LOSS OF BOWELL CONTROL | LOSS OF BLADDER CONTROL | NEUROLOGICAL DISORDER |
| MENTAL DISEASE | DEPRESSION | DERMATITIS/ECZEMA/RASH | LIVER DISORDER |
| VOMITING | SCOLIOSIS | SCIATICA | SWELLING OF JOINTS |
| BRUISE EASILY | NERVOUSNESS | THYROID CONDITION | EAR RINGING |
| VENEREAL DISEASE | EYE PAIN/DIFFICULTIES | OTHER: | OTHER: |

PLEASE EXPLAIN ANY OF THE ABOVE IF YOU HAVEN'T DONE SO ALREADY:

FOR FEMALES ONLY: DO YOU HAVE MENSTRUAL PROBLEMS? YES NO
DO YOU TAKE BIRTH CONTROL? YES NO
IS THERE A CHANCE YOU ARE CURRENTLY PREGNANT? YES NO

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US OR THINK WE SHOULD KNOW?

SIGNATURE: _____ DATE: _____

(SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN IF PATIENT IS UNDER 18)