SLAGLE
Family Wellness Center

WELCOME

PATIENT INFORMATION

Date

Name

Address

Birthdate Sex

Single Married Separated Divorced Widowed

Patient SS#

Occupation

Employer Address

Employer Phone

Spouse's Name

Spouse's Employer

Whom may we thank for referring you?

INSURANCE

Account Holder

Relation to Patient

Insurance Co.

Member ID #

Additional Insurance Co?

Birthdate SS#

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with the above co. and assign directly to the Dr. all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dr. to release information necessary to secure the payment of insurance benefits. Signature

PHONE NUMBERS

Home Cell

E-mail address

Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT:

Name

Phone Number

ACCIDENT INFORMATION

Is condition due to an accident Y/N Date

Type of accident (Circle) Auto Work Home Other

To whom, have you made a report of accident?

(Circle) Auto Insurance Employer Workers Comp. Other

Attorney Name (If Applicable)

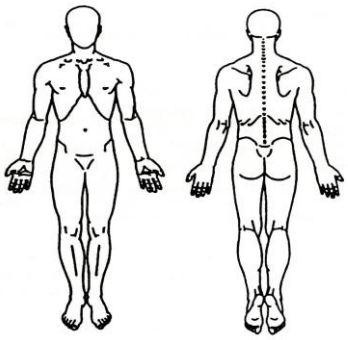
PATIENT CONDITION

Reason for Visit

When did your symptoms appear?

Is this condition getting worse? Y/N

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)

Describe the type of pain (sharp, dull, throbbing, numbness aching, shooting, burning, tingling, cramps, stiffness, swelling)

How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with your (circle): Work, Sleep, Daily Routine, Recreation

Activities or movements that are painful to perform (circle): Sitting, Standing, Walking Bending, Laying Down

Have you seen a chiropractor for this or any other condition? Y/N If yes, for what?

Addition information regarding your current or past health you would like to share with the Dr: