MARK GORBAHN CHIROPRACTIC, INC

NAME________________________________ MALE FEMALE DECLINE TO DISCLOSE
ADDRESS____
CITY___________________________ STATE_________________ ZIP_____________________
HOME PHONE #____________________________CELL #________________________________
WORK#____________________________________DATE OF BIRTH______________________

IF YOU WOULD LIKE A COPY OF YOUR MEDICAL RECORDS:
A) PAPER COPY OF MEDICAL RECORDS (WHEN NEEDED) UPON REQUEST: YES NO

OR

B) AN EMAIL OF MEDICAL RECORDS EACH TIME YOU ARE SEEN: YES NO
IS YES, PLEASE PROVIDE EMAIL ADDRESS____

COMMUNICATION PREFERENCE: CELL EMAIL HOME WORK

PREFERRED LANGUAGE: (EG. ENGLISH) ________________________________

STATUS: MARRIED SINGLE OTHER DECLINE TO DISCLOSE

IS THERE ANY PERSON YOU WANT TO HAVE ACCESS TO YOUR MEDICAL RECORDS: YES NO
(EG: SPOUSE, MOTHER, FATHER) NAME(S) AND PHONE NUMBER
____
____

EMERGENCY CONTACT:
NAME:_____________________________________PHONE#____________________________

PLEASE BE AWARE IF YOU ARE REFERRED TO ANOTHER DOCTOR OR FACILITY WE WILL SEND A COPY OF THIS FORM (INCLUDING YOUR DRIVERS LICENSE AND INSURANCE INFORMATION) TO THEIR OFFICE.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO FILE AN INSURANCE CLAIM ON MY BEHALF WITH MY INSURANCE CARRIER OR WORKER'S COMPENSATION CARRIER. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBIBLE FOR ALL BALANCES NOT PAID BY MY INSURANCE FOR ANY REASON, AND PROMISE TO MAKE PROMPT PAYMENT OF ANY OUTSTANDING AMOUNTS. I ALSO AGREE TO PERSONALLY PAY, IN FULL, ANY BILL THAT IS UNREASONBLY DELAYED BY LITIGATION.

____
PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**

WELCOME TO MARK GORBAHN CHIROPRACTIC, INC

PATIENT NAME________________________________ **DATE**______________________

REASON FOR TODAY'S VISIT

EXPLAIN WHAT HAPPENED____

____

DESCRIBE THE PAIN AND LOCATION____

____

____

WHAT IS YOUR PAIN LEVEL? SCALE OF 1-10

TODAY________ YESTERDAY__________ FOR THE WEEK____________________

WHEN DID THE CONDITION BEGIN______________________________________

IS THIS CONDITION GETTING WORSE? YES NO CONSTANT COMES AND GOES

IS THIS CONDITION INTERFERING WITH YOUR: WORK SLEEP DAILY ROUTINE
IF YES PLEASE EXPLAIN____

HAVE YOU HAD THIS OR SIMILAR CONDITION(S) IN THE PAST? YES NO
IF YES PLEASE EXPLAIN____

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS CONDITION?
YES NO IF YES----WHERE?____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR BEFORE? YES NO
IF YES---- WHOM?_____________________________ PHONE#______________________

HOW DID YOU HEAR ABOUT DR. GORBAHN?_____________________________________

____

I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I AUTHROIZE THE PROVIDER AND/OR MANAGED CARE ORGANIZATION TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CALIMS.

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS **MY RESPONSIBILITY** TO INFORM THIS OFFICE OF ANY CHANGES TO THE INFORMATION I HAVE PROVIDED

SIGNATURE OF RESPONSIBLE PARTY____

NAME______________________________**DATE**____________________

PLEASE LIST: PRESCRIPTION MEDICATIONS YOU ARE TAKING

1)______________________________ 2)______________________________
3)______________________________ 4)______________________________
5)______________________________ 6)______________________________

PLEASE LIST: PRESCRIPTION ALLERGIES (EG: SULFA)

____
____

SMOKING FREQUENCY: PLEASE EXPLAIN: (EG: NEVER SMOKED, SMOKER)

____

FAMILY HISTORY OF ILLNESS (EG. HEART DISEASE)____________________
____

PLEASE LIST **ANY** SERIOUS MEDICAL CONDITION(S) YOU HAVE OR HAD
EX: HEART DISEASE, DIABETES, HIGH BLOOD PRESSURE

____
____

HAVE YOU EVER:	**NO**	**YES**	**BRIEFLY EXPLAIN (INCLUDE YEAR)**
BROKEN BONES	___	___	____________________
HOSPITALIZATIONS	___	___	____________________
AUTO ACCIDENT	___	___	____________________
SPRAINS/STRAINS	___	___	____________________
STRUCK UNCONSCIOUS	___	___	____________________
HAD SURGERY	___	___	____________________
OTHER			____________________

Do you take Supplements or Vitamins **NO** ____ **YES** _____ **EXERCISE NO**___ **YES** ____

ARE YOU ON A SPECIAL DIET **NO**___ **YES** ___ **FOR HOW LONG** ________

ARE YOU PREGNANT NO____ YES____ **HOW MANY WEEKS** _________
NURSING NO ______ **YES** ______