JESTER FAMILY CHIROPRACTIC, P.C.

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, completely and accurately. THANK YOU.

Date_____ Home Phone_____ Cell Phone_____ Carrier_____

Name_____ Email_____

Street_____ City_____ Zip Code_____

Age _____ Birth Date_____ Heard about our office through / referred by: _____

Have you ever been to a Chiropractor? Y / N Last Adjustment Date: _____ Last X-ray Date: _____

Occupation _____ Employer _____ Satisfaction with Career: great okay unhappy

Please List Present Complaints and Date of Onset:

1. _____ 2. _____

3. _____ 4. _____

Please use the following symbols on the pain diagram to accurately describe your condition.

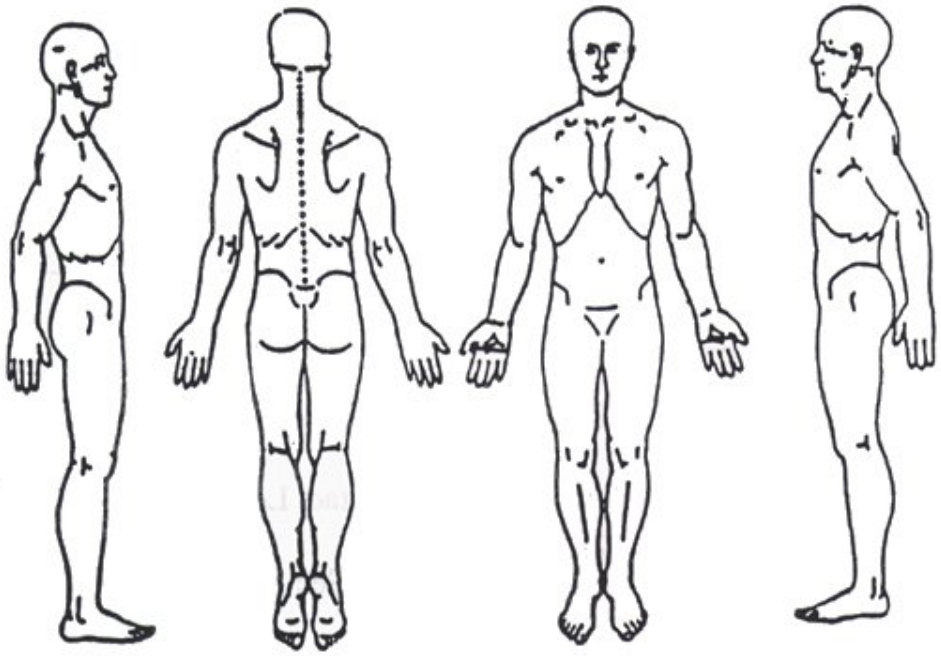
PPP Where you experience Pain

NNN Where you experience Numbness

TTT Where you experience Tingling

BBB Where you experience Burning

CCC Where you experience Cramping



Complaint History:

1. How long have you had this condition? _____ Date of Onset: _____

2. How would you describe your pain? (circle all which apply) sharp / soreness / throbbing / tingling / dull / stiffness / spasm / burning / ache / weakness / numbness / tingling / other _____

3. How would you rate the intensity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Moderate pain) (Terrible pain)

4. Pain radiates or travels? NO. YES. Describe: _____

5. How often is the pain present? Constant (81-100%) Frequent (51-80%) Occasional (26-50%) Infrequent (>25%)

6. Since your problem began, is the pain: getting worse / getting better / staying the same

7. How did your problem begin? gradual / sudden / no specific reason / auto accident / work related accident

8. What makes your problem better? nothing / walking / standing / sitting / exercise / lying down / inactivity / medication

9. What makes your pain worse? nothing / walking / standing sitting / exercise / lying down / inactivity

10. What is your physical activity at work? computer work / mostly sitting / light / moderate / heavy manual labor

11. What is your present mental and emotional stress level? none / minimal / moderate / greatly stressed

12. Is your problem affecting your ability to work or perform daily activities? no effect / some effect / greatly effected

13. If it is affecting your daily living, what areas are affected? sleeping / hearing / running / sexual function / eating / standing / lifting / bending / driving / walking / tasting / smelling / bathing / typing / exercising / emotional / sitting / sports

14. Where in your body do you carry your stress?_____

15. What tools have you used to reduce your stress? _____

16. Why do you think your body failed to heal itself this time? _____

17. What bad habits do you need to release?_____

18. Do you know why your brain and nerve system are called the Master Control System? Yes / No / Unsure

19. How many hours of sleep do you get each night?____ Do you have trouble sleeping or falling to sleep? Yes / No / Some

20. What is your level of commitment to your self, your life and well being? high / medium / low

21. Are you willing to invest time, money and energy in taking better care of your health at this time? _____

22. What are the three most significant emotional traumas in your life? _____

_____

List other doctors consulted for present complaints and injuries:

Name: _____ What kind of doctor? _____ When _____

Diagnosis: _____ Treatment / x-rays: _____

How long did you see the doctor? _____ How frequently? _____

Result: Good / Not Good / Okay / Other: _____

Present family doctor _____ Last exam date: _____ Reason for Visit: _____

What surgeries have you had? Type: _____date: _____

Type: _____ Outcome Results:_____ date: _____

List former serious accidents and falls: (auto, work, home, leisure, sports, other)

What / When / Treatments / Results: _____

_____

List broken bones: What / When / Remarks: _____

List medications / diet supplements you currently take: _____

What / Frequency / Dosage / Side Effects / Prescribing Doctor: _____

Assignment of Benefits: I hereby irrevocably instruct and direct my insurance company to pay JESTER FAMILY CHIROPRACTIC, PC directly. For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. I also authorize the release of any health information pertinent to my case to any insurance company, Health Care Financing Administration or its agents, or attorney involved in this case. I authorize the doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf. I understand all the information on this form and I answered it true and correct to the best of my ability.

_____ _____ _____

Signature Print Name Date