PATIENT INFORMATION

Today's Date: _____

NAME: _____ Date of Birth: _____ Age: _____

Address: _____ City, State, Zip: _____

Provide two phone #s where we may contact you: _____H C W _____H C W

Occupation: _____ Marital Status: S , M , D , W

Emergency Contact: _____ Phone #: _____

How did you hear about us? _____ Have you received chiropractic care before? Y N

IS TREATMENT RELATED TO: Auto Accident Work Accident Other Accident

Will you be using insurance with us? Y N Name of Insurance: _____

You, the patient, understand that this is a cash practice. If you so choose to use insurance, Dr. Jena Friedel's office will bill for you, but you will ultimately be 100% responsible for the payment of services in full. Your signature on the next page shows that you understand and agree to these terms and that you authorize Dr. Jena Friedel's office to release your medical information to other medical providers and insurance companies if your medical care necessitates it.

Have you ever had the following:

	YES / NO
Heart disease (high blood pressure, clots, pacemaker, etc)	____/____
Kidney disease (dialysis, bladder, etc)	____/____
Lung disease (asthma, tuberculosis, shortness of breath, etc)	____/____
Gastrointestinal disorder (ulcers, hepatitis, liver disease, colon, etc)	____/____
Diabetes	____/____
Cancer of any sort	____/____
Ear-eye-nose throat conditions (sinus, glaucoma, tonsils, etc)	____/____
Genitourinary conditions (infections, incontinence, menopause, etc)	____/___
Pregnancies (miscarriages, births, currently pregnant)	____/____
Musculoskeletal conditions (arthritis, fibromyalgia, etc)	____/____
Stroke (including any vascular disease)	____/____

Do you smoke or use tobacco? Y N Do you consume alcohol? Never Some Moderate Heavy

List any allergies: _____

Past surgeries: _____

Current Medications:_____

List any illness that have or are affecting immediate family members: _____

_____

Purpose for this appointment? _____

_____

How did this start? _____ When? _____

Have you ever had this problem in the past? Y N When? _____

Has the problem been getting: Better Worse Staying the same

Does it occur: Constant Daily Intermittent Night only Only with certain activities

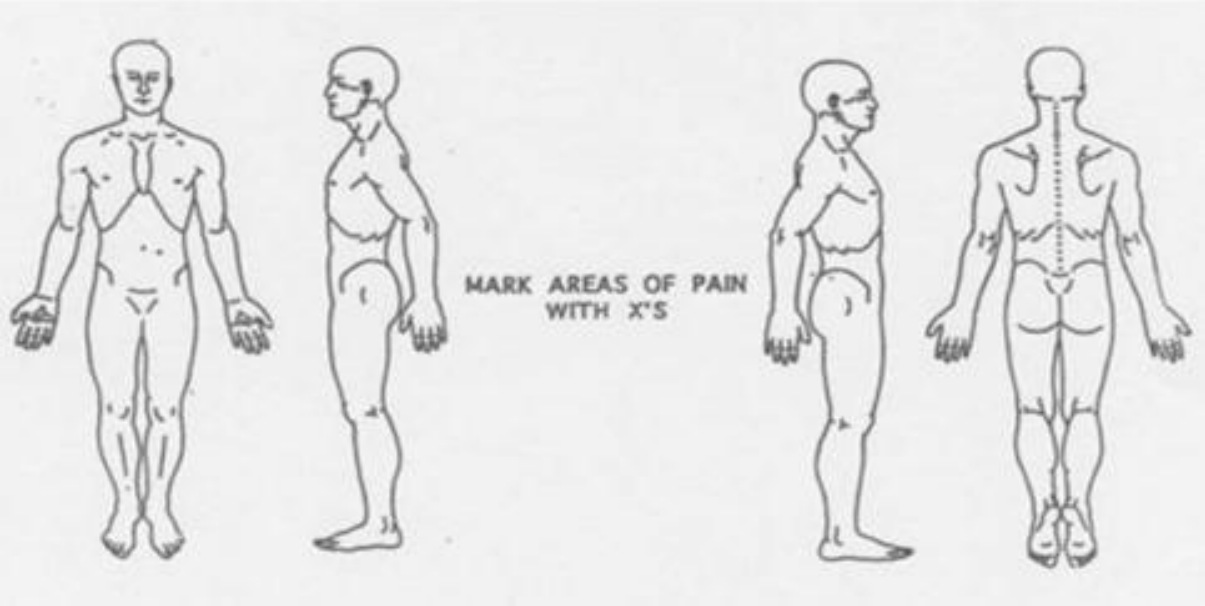
Is the pain: Sharp Dull Aching Burning Numb Tingling Other

What makes the pain worse? Standing Sitting Laying Bending Lifting Twisting Other

Is there anything that relieves the pain? Y N Describe: _____

Please rate your pain level on the scale (0 = no pain, 10= worst pain, lets go to the ER)

1 2 3 4 5 6 7 8 9 10



I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Jena Friedel responsible for errors or omissions that I may have made in the completion of this form.

If minor: I authorize Dr. Jena Friedel to perform exams and render chiropractic care/adjustment to my minor child, _____. As of this date, I have the legal right to select and authorize health care services for the minor child name above:

Patient/Guardian Signature:_____ Date: _____