



PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED

PATIENT INFORMATION

Form fields for Patient Information including Last Name, First Name, Middle Initial, Nickname, Street or Mailing Address, City, State, Zip Code, Gender, Date of Birth, No of Children, Home phone, Marital Status, Spouse Name, Cell phone, Soc. Sec. No., Driver's License #, State Issued, Work phone, Currently employed?, Occupation, Employer, E-mail, Referred By, and Closest relative besides your spouse.

INSURANCE INFORMATION

Insurance Information form with questions: Do you have health insurance?, Is your visit related to a work injury? (*), Is this visit related to an auto accident? (*), and fields for Name of Company, Injury date, Accident date, Phone number, Claim #, and Contact person.

INSURANCE MEMBER OR RESPONSIBLE PARTY FOR PAYMENT

Form fields for Insurance Member or Responsible Party for Payment including Last Name, First Name, Middle Initial, Nickname, Street or Mailing Address, City, State, Zip Code, Gender, Date of Birth, Home phone, Relationship to Patient, Cell phone, Soc. Sec. No., Driver's License #, State Issued, Work phone, Currently employed?, Occupation, and Employer.

I authorize the release of any medical information necessary to processing this claim and all future claims. I also authorize payment of medical benefits to undersigned provider or supplier for these services and all future claims. X Please sign

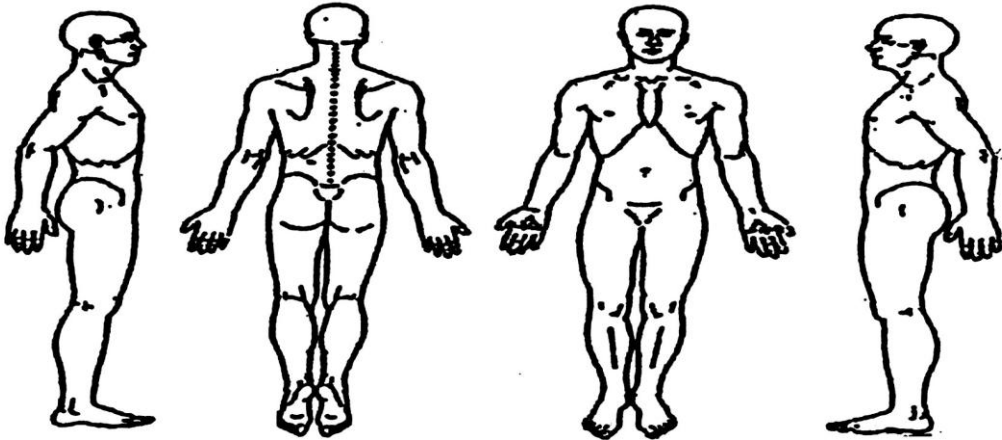
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature and Date lines for Patient signature and Or Guardian's signature.

Patient Name: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What alleviates your condition?

15. What concerns you the most about your problem; what does it prevent you from doing?

16. What is your: Height _____ Weight _____ DOB _____ Age _____
Occupation _____

17. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

**PATIENT ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE**

I hereby acknowledge receipt of the Notice of Privacy Practices for **Greene Chiropractic** regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **Christopher Greene, D.C., 1145 S. Camino del Rio, Suite #120, Durango, CO 81303, 970-375-1590.**

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for **Greene Chiropractic.**

Patient Signature

Date

Patient's Legal Representative
if required

Date

If signed by patient's legal representative, please state representative's relationship to patient:
