Welcome

Patient Information

Date _____

SS/HIC/ID _____

_____

Patient Name _____
Last First M.I.

Address _____

City_____ State_____ ZIP_____

E-Mail _____

Sex □ M □ F Age_____ Birthdate _____
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for _____ years

Occupation _____

Patient Employee/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____/_____/_____ SS#_____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home (_____) _____ Cell(_____) _____

Best Time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship_____

Home (_____)_____ Work (____)_____

Insurance

Who is responsible for the account? _____

Relationship to Patient: _____

Insurance Co _____

Group # _____

Is patient covered by additional insurance? □Yes □ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____Group#_____

Assignment And Release

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Name of Insurance Company(ies)

Dr. Horning all insurance benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient/Parent/Guardian Print Name

_____ _____
Date Relationship to Patient

ACCIDENT INFORMATIOIN

Is condition due to an accident? □ Yes □ No

Date_____ Type of Accident □ Auto □ Work □ Home □ Other
To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp □ Other

ATTORNEY NAME (If applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Type of Pain □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain? _____ □ Constant □ Comes and Goes
Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Health History

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy □ Chiropractic □ Other _____

Name and Address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray _____ Blood Test _____

Spinal Exam_____ Chest X-Ray _____ Urine Test _____

Dental Exam_____ MRI, CT Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following

AIDS/HIV □ Yes □ No
Alcoholism □ Yes □ No
Allergy Shots □ Yes □ No
Anemia □ Yes □ No
Anorexia □ Yes □ No
Appendicitis □ Yes □ No
Arthritis □ Yes □ No
Asthma □ Yes □ No
Bleeding Disorders □ Yes □ No
Breast Lumps □ Yes □ No
Bronchitis □ Yes □ No
Bulimia □ Yes □ No
Cancer □ Yes □ No
Cataracts □ Yes □ No
Chemical Dependency □ Yes □ No
Chicken Pox □ Yes □ No
Diabetes □ Yes □ No
Emphysema □ Yes □ No
Epilepsy □ Yes □ No
Fractures □ Yes □ No
Glaucoma □ Yes □ No
Goiter □ Yes □ No
Gonorrhea □ Yes □ No
Gout □ Yes □ No
Heart Disease □ Yes □ No
Hepatitis □ Yes □ No
Hernia □ Yes □ No
Herniated Disk □ Yes □ No
Herpes □ Yes □ No
High Cholesterol □ Yes □ No
Kidney Disease □ Yes □ No
Liver Disease □ Yes □ No
Measles □ Yes □ No
Migraine Headaches □ Yes □ No
Miscarriage □ Yes □ No
Mononucleosis □ Yes □ No
Multiple Sclerosis □ Yes □ No
Mumps □ Yes □ No
Osteoporosis □ Yes □ No
Pacemaker □ Yes □ No
Parkinson's Disease □ Yes □ No
Pinched Nerve □ Yes □ No
Pneumonia □ Yes □ No
Polio □ Yes □ No
Prostate Problem □ Yes □ No
Prosthesis □ Yes □ No
Psychiatric Care □ Yes □ No
Rheumatoid Arthritis □ Yes □ No
Rheumatic Fever □ Yes □ No
Scarlet Fever □ Yes □ No
Stroke □ Yes □ No
Suicide Attempt □ Yes □ No
Thyroid Problems □ Yes □ No
Tonsillitis □ Yes □ No
Tuberculosis □ Yes □ No
Tumors, Growths □ Yes □ No
Typhoid Fever □ Yes □ No
Ulcers □ Yes □ No
Vaginal Infections □ Yes □ No
Venereal Disease □ Yes □ No
Whooping Cough □ Yes □ No
Other _____

Exercise: □ None □ Moderate □ Daily □ Heavy

Work Activity: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Habits:

□ Smoking Packs a Day _____ □ Alcohol Drinks/Week _____

□ Coffee/Caffeine Drinks Cups/Day _____ □ High Stress Level Reason_____

Injuries/Surgeries you have had **Date**

Falls _____ _____

Head Injuries _____ _____

Broken Bones _____ _____

Dislocation _____ _____

Surgeries _____ _____

Medications _____

Allergies _____

Vitamins/Herbs _____