Case No. _____

Last Name: _____ First Name _____ Middle Name _____

Address: _____ BIRTHDATE___/___/___ AGE _____

City: _____ State: _____ Zip _____

Occupation _____ Spouse _____

Employer _____ Spouse Occupation _____

# of Chidren ___ Phone: _____ Work: _____ Cell: _____ Email: _____

Contact in case of emergency: _____ Referred by: _____

What is your major complaint? _____

_____

_____

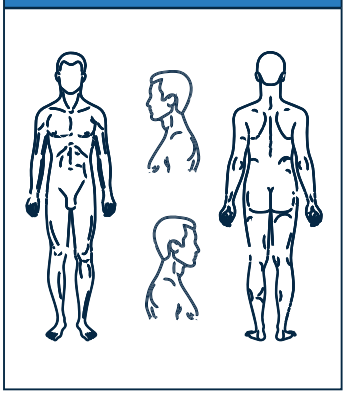
Other complaint? _____

How long have you had this condition? _____

Have you had this or a similar condition in the past _____

is this condition getting progressively worse? Yes No Constant Come and goes

Please mark your areas of pain on the figures below



Neck Problems
Shoulder Problems
Arm Problems
Numbness - Arms
Pain Between Shoulders
Low Back Problems
Leg Problems
Numbness - Legs
Loss of Feeling
Stiff Joints
Painful Joints
Restricts Daily Activities
Restricts Regular Excercise

Sore Muscles
Walking Problems
Broken Bones
Muscle Cramps
Weak Muscles
Headaches
Dizziness
Fainting
Forgetfulness
Depression
Vision Problems
Ear Palm / Noises
Hearing Loss
Frequent Colds

Allergies
Hay Fever
Asthma
Eczema
Shingles
Nausea
Poor Digestion
Ulcers
Diarrhea
Constipation
Kidney Infection
Menstrual Cramps
Diabetes
Blood Presssure
High / Low
Tiredness / Fatigue

- This is a new / old illness. It was not / was treated before.
  If treated before, what was done? _____
- Name of Doctors: _____
- Have you ever hd surgery or been hospitalized? Yes No
  List Surgerries: _____ Date _____
- Have you ever had Chiropractic care before? Yes No
  Name of Doctor _____ Date ___/___/___
- Last time you had spinal X-rays or other X-rays: _____
- Medications you now take: _____
- Female: Are you pregnant at this time? _____

Sign & Date: _____ ___/___/___

From birth to present please list by date / describe

1) Car Accidents _____

_____

_____

2. Falls / Injuries (including Sports)

_____

_____

3. Other

_____

_____

HIPAA PRIVACY ACT FORM

Release of information for Reimbursement. To the extent necessary to obtain reimbursement, the Facility may disclose any portion of the patient's record including, but not limited to, insurance companies, healthcare service plans, workers compensation carriers, social security administration, and peer review organizations.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account of the facility in accordance with regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Assignment of insurance benefits: The undersigned authorizes, whether he/she signs agent or as patient direct payment to the facility of any insurance benefits otherwise payable to the undersigned for services rendered as a rate not to exceed the facility's usual and customary charges. It is agreed that the payment to the facility, pursuant to the authorization, by an insurance company Health Care Services plan shall discharge said insurance company Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not converted by this assignment

Health Care Service Plans: The Facility has contracted with multiple Health Care Service Plans, It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services as the Facility, The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health care Service Plan to the Facility. For non-emergency services if is the patient's responsibility to ensure/his/her Plan authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergency services will be considered a denial for a non-covered benefit and payable by the undersigned.

The Undersigned acknowledges he/she understands the Notice of Privacy Practice and he/she has received a copy of the Notice of Privacy Practices. The undersigned acknowledges he/she understands the Financial Agreement, Assignment of Insurance benefits Health Care Services Plan obligation and all the other application provisions above and received a copy thereof, and is the patients, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accepts its terms

_____	_____	_____
SIGNATURE PATIENT	DATE	RELATIONSHIP IF NOT PATIENT