



Patient Name _____ Birthdate _____ Sex: M / F
Address _____ City _____
State _____ Zip _____ Phone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

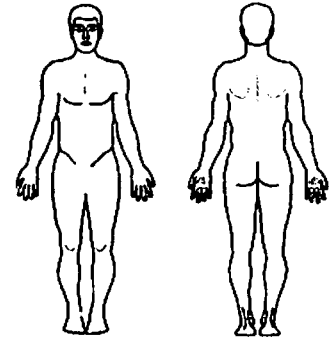
- Headache Neck Pain Mid-Back Pain Low Back Pain
 Other _____

Is this? Work Related Auto Related N/A

Date Problem Began _____

How Problem Began

Current complaint (how you feel today):
|-----|
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain



How often are your symptoms present?

- (Occasional) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

|-----|
No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant, # Weeks _____ |
| <input type="checkbox"/> Stroke (Date) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco Use - Type _____ |
| <input type="checkbox"/> Epilepsy/Seizures | Frequency _____ /Day |
| <input type="checkbox"/> Other Health Problems (Explain) _____ | <input type="checkbox"/> Medications _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____

(OVER)

AHRENS CHIROPRACTIC PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Nick Name _____ Social Security Number _____

Cell Phone _____ Email _____

Age _____ M S W D Number of Children _____

****Who (or how) were you referred to our office?** _____

Would you prefer to (circle one) Fix the problem / Patch the problem

Is your condition the result of an auto accident? Y N

Do you have Secondary Insurance Y N Name _____

I understand and agree that health insurance policies are an arrangement between my insurance carrier and me. I understand that this office will prepare initial billings to assist me in making collections from my insurance company and that any amount authorized will be credited to my account upon receipt. I clearly understand that if I am responsible for payment for all services rendered to me. I also understand that if I terminate my care, any professional fees for services rendered will become due and payable immediately.

Patient or Guardian's Signature **X** _____ today's date _____

All patients please provide a copy of your insurance card and completed form to the receptionist (PPO, HMO, personal injury insurance, car insurance info, etc.)

PATIENT CONSENT FORM FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me, or on the patient named below for whom I am legally responsible, at Ahrens Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment at this office.

Patient's name (please print) date

Patient's signature (or guardian if patient is a minor)

RELEASE OF MEDICAL INFORMATION

To _____ Date _____

You are hereby authorized and requested to furnish to AHRENS CHIROPRACTIC any and all medical information, history, records, diagnosis, reports, or x-rays in your possession concerning the undersigned to:

AHRENS CHIROPRACTIC
629 Camino de los Mares, Suite 104
San Clemente, CA 92673
949-240-1334 fax 949-240-4434
www.ahrenschiro.com

X _____
Signature of Patient or Guardian

rev 9/6/09