PLEASE FILL OUT THE FOLLOWING INFORMATION TO THE BEST OF YOUR ABILITY:

FIRST NAME:_____ LAST NAME:_____ DATE:_____

CURRENT ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____ SEX:____ OCCUPATION:_____ EMPLOYER:_____

TELEPHONE (CELL): _____ (HOME):_____ E-MAIL:_____

EMERGENCY CONTACT:_____ PHONE:_____ RELATION:_____

HOW DID YOU HEAR ABOUT US?_____

FAMILY DOCTOR:_____ ADDRESS:_____ PHONE:_____

DATE LAST SEEN:_____ WHAT WERE YOU SEEN FOR:_____ OUTCOME:_____

REFERRING DOCTOR:_____ ADDRESS:_____ PHONE:_____

PRIMARY INSURANCE INFO:

POLICY HOLDER'S NAME:_____ RELATIONSHIP TO PATIENT:_____

POLICY HOLDER'S DATE OF BIRTH:_____ NAME OF INSURANCE COMPANY:_____

IF IN AUTO ACCIDENT/WORK COMP. INJURY, PLEASE PROVIDE:

NAME OF INSURANCE COMPANY:_____ CONTACT PERSON:_____

PHONE NUMBER:_____ CLAIM NUMBER:_____ DATE OF ACCIDENT:_____

SECONDARY INSURANCE INFO (IF APPLICABLE):

POLICY HOLDER'S NAME:_____ RELATIONSHIP TO PATIENT:_____

POLICY HOLDER'S DATE OF BIRTH:_____ NAME OF INSURANCE COMPANY:_____

RELEASE OF INFORMATION

I AUTHORIZE FULL STRENGTH SPINE AND HEALTH CENTER AND ITS STAFF TO RELEASE TO THE ABOVE COMPANY(IES) OR ITS REPRESENTATIVES, TO MYSELF, TO MY PRIMARY CARE PHYSICIAN OR REFERRING PHYSICIAN ANY INFORMATION USED FOR TREATMENT AND PAYMENT.

ASSIGNMENT OF BENEFITS

I UNDERSTAND AND AGREE THAT HEALTH/ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND AND AGREE THAT ALL SERVICES REDERED TO ME AND CHARGED ARE MY PERSONAL RESPONSIBILITY FOR TIMELY PAYMENT. I UNDERSTAND IF I TERMINATE MY CARE/TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

CONSENT TO TREATMENT

I _____ (PRINT NAME) KNOWING THAT I HAVE A CONDITION REQUIRING DIAGNOSIS AND TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO DIAGNOSTIC EXAMINATION PROCEDURES AND TREATMENT BY DR. TIMOTHY R. GILBERT, D.C.

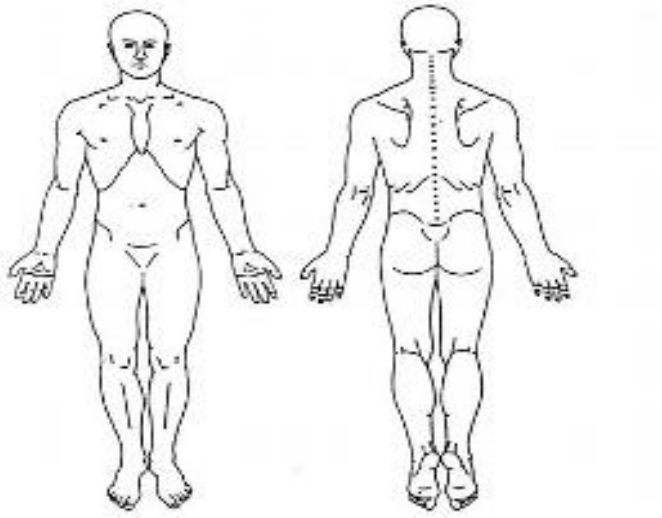
SIGNATURE:_____ DATE:_____

(SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN IF PATIENT IS UNDER 18)

HISTORY OF PRESENT ILLNESS

CURRENT COMPLAINTS:

USE THE DIAGRAM BELOW TO INDICATE WHERE YOUR PAIN IS LOCATED:



USE SYMBOLS TO DESCRIBE YOUR PAIN:

- SHARP = \ \ \ \ \
- BURNING = XXXX
- PINS/NEEDLES = OOOO
- NUMB = NNNN
- DEEP/DULL ACHE = DDDD
- STIFFNESS = SSSS
- OTHER (PLEASE SPECIFY):

DATE CURRENT SYMPTOMS BEGAN:_____

PLEASE GIVE A BRIEF DESCRIPTION OF HOW THE SYMPTOMS BEGAN:

_____

_____

_____

RATE YOUR PAIN ON A SCALE OF 0-10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN IMAGINABLE:____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?_____

DOES THE PAIN RADIATE ANYWHERE?____YES ____NO IF YES, WHERE TO?_____

WHAT MAKES YOUR PROBLEM WORSE?_____

WHAT MAKES YOUR PROBLEM BETTER?_____

IS THERE ANY ASSOCIATED SYMPTOMS(FEVER, FATIGUE, UNINTENTIONAL WEIGHT LOSS, NIGHT SWEATS)?_____

IF YES, PLEASE EXPLAIN_____

DOES YOUR PROBLEM WAKE YOU UP AT NIGHT?____YES ____NO

WHAT TIME OF DAY ARE YOUR SYMPTOMS WORSE (IE MORNING, AFTERNOON, ETC)?_____

HAS THIS PROBLEM INTERFERRED WITH YOUR WORK AND DAILY ACTIVIES (CHECK ALL THE APPLY)?

____NOT AT ALL ____A LITTE ____MODERATELY ____QUITE A BIT ____EXTREMELY

HAVE YOU EVER HAD THE SAME CONDITION? ____YES ____NO IF YES, WHEN?_____

PLEASE EXPLAIN:_____

HAVE YOU SEEN ANY OTHER PRACTIONERS FOR YOUR CURRENT COMPLAINT? ____YES ____NO

IF YES, WHO AND PLEASE DESCRIBE:_____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? ____YES ____NO

IF YES, PLEASE DESCRIBE/WHEN?_____

DID YOU RECEIVE ANY DIAGNOSTIC IMAGING?

____XRAY ____MRI ____CT ____OTHER:_____ DATE TAKEN?_____

SIGNATURE:_____ DATE:_____

PAST MEDICAL HISTORY

DO YOU HAVE ALLERGIES: ____YES _____NO IF YES, PLEAST LIST_____

PLEASE LIST ALL MEDICATIONS/VITAMINS/SUPPLEMENTS YOU CURRENTLY TAKE:

_____

_____

PLEASE LIST ALL CURRENT AND PAST MEDICAL CONDITIONS:

_____

_____

PLEASE LIST ALL REASONS YOU MAY HAVE BEEN HOSPITALIZED IN THE PAST:

_____

_____

PLEASE LIST ALL SURGICAL PROCEDURES AND MAJOR TRAUMA (IE, BROKEN BONES) YOU HAVE HAD:

_____

_____

PLEASE LIST ALL PRIMARY FAMILY MEMBERS HEALTH HISTORY (IE, HEART DISEASE, DIABETES, CANCER (BE SPECIFIC HERE), ARTHRITIS, ALS):

_____

_____

DO YOU SMOKE?____YES ____NO IF YES, HOW MANY CIGARETTES PER DAY?_____

HOW WOULD YOU DESCRIBE YOUR ALCOHOL INTAKE (CIRCLE ONE): NONE LIGHT MODERATE HEAVY

PLEASE CIRCLE ANY OF THE FOLLOWING IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE CONDITIONS LISTED:

ALLERGIES	ANEMIA	ARTHRITIS	BACK PAIN
BREAST LUMP	CANCER	CHEST PAIN	DIFFICULTY BREATHING
HEADACHES	RHEUMATOID ARTHRITIS	HIGH BLOOD PRESSURE	STROKE
ANGINA	PROSTATE PROBLEMS	DIABETES	HIGH CHOLESTEROL
KIDNEY STONES	KIDNEY INFECTION	DIARRHEA/CONSTIPATION	HEMORRHOIDS
IRREGULAR HEART BEAT	PACEMAKER	DIGESTIVE PROBLEMS	NUMBNESS/TINGLING
ULCER	LOSS OF BOWELL CONTROL	LOSS OF BLADDER CONTROL	NEUROLOGIC DISORDER
MENTAL DISEASE	DEPRESSION	DERMATITIS/ECZEMA/RASH	LIVER DISORDER
VOMITING	SCOLIOSIS	SCIATICA	SWELLING OF JOINTS
BRUISE EASILY	NERVOUSNESS	THYROID CONDITION	EAR RINGING
VENEREAL DISEASE	EYE PAIN/DIFFICULTIES	OTHER:	OTHER:

PLEASE EXPLAIN ANY OF THE ABOVE IF YOU HAVEN'T DONE SO ALREADY:

_____

_____

FOR FEMALES ONLY: DO YOU HAVE MENSTRUAL PROBLEMS?____YES____NO

DO YOU TAKE BIRTH CONTROL?____YES____NO

IS THERE A CHANCE YOU ARE CURRENTLY PREGNANT?____YES____NO

SIGNATURE:_____ DATE:_____