NEW PATIENT INFORMATION

Full Name _____ MI _____ DOB ___/___/____ Male☐ Female☐

Address _____ Apt. # _____

City _____ State ____ Zip Code _____ Marital Status: S M W D

Social Security No. _____/____/_____ E-mail: _____

Phone (H) _____ (W) _____ (C) _____

Employer _____ Employer Phone Number _____

Emergency Contact (Name & Phone No.) _____

Who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

Auto Accident☐ (Date: / /) Long Term Injury Issue ☐ New Injury/Issue ☐

FIRST COMPLAINT AREA: _____

- Date when symptom first appeared (or estimated) _____
- What makes the symptoms increase? _____
- Type of Pain ___ Sharp ___ Dull ___ Ache ___ Burn ____ Throb ____Stabbing ___Tightness/Stiffness
- Does the pain radiate into your: ___ Arm/Hand ___ Leg/Feet _____Other ____ Does not radiate
- Do you experience numbness or tingling? ____ Yes ____ No Where? _____
- How often do you experience these symptoms? ____100% ____75% ____50% ____25% _____10%
- PAIN INTENSITY: On a 1-10 scale, 10 being the worst, rate the pain you are feeling today _____

SECOND COMPLAINT AREA: _____

- Date when symptom first appeared (or estimated) _____
- What makes the symptoms increase? _____
- Type of Pain ___ Sharp ___ Dull ___ Ache ___ Burn ____ Throb ____Stabbing ___Tightness/Stiffness
- Does the pain radiate into your: ___ Arm/Hand ___ Leg/Feet _____Other ____ Does not radiate
- Do you experience numbness or tingling? ____ Yes ____ No Where? _____
- How often do you experience these symptoms? ____100% ____75% ____50% ____25% _____10%
- PAIN INTENSITY: On a 1-10 scale, 10 being the worst, rate the pain you are feeling today _____

Past Surgeries: _____

_____

_____

Other Illnesses you are being treated or have been treated for: _____

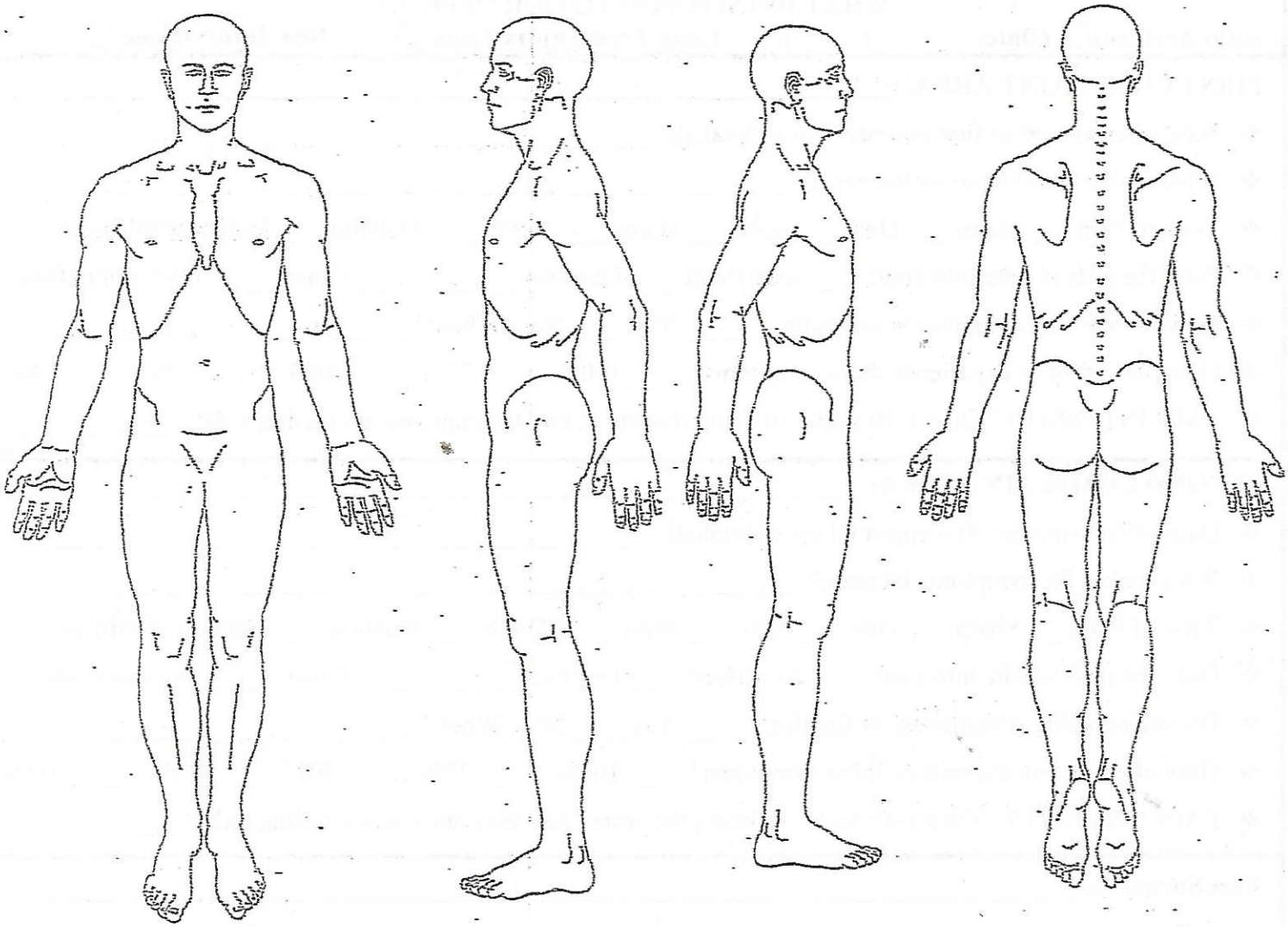
_____

I agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable. If it becomes necessary, any collection/attorney fees are my responsibility. Ten percent interest may apply on balances 90 days past due if there is no good-faith effort to pay such balance. Also, I authorize the release of any medical information required to process an insurance claim on my behalf.

If, for any reason, the above request cannot be met, arrangements must be made before seeing the doctor.

PATIENT'S SIGNATURE_____ DATE_____

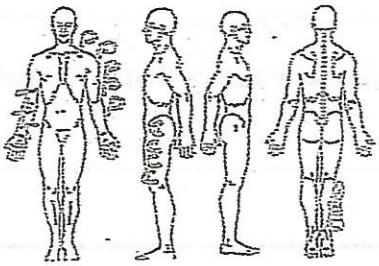
Responsible party signature if patient is minor.



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramping

EXAMPLE



CONSENT FOR TREATMENT
AND
AUTHORIZATION TO PERFORM X-RAYS

Date_____ Time_____(AM / PM)

I have been informed by Dr. Stephen W. Sieradzki, D.C. that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Stephen W. Sieradzki, D.C. to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed:_____

Witness:_____

To the best of my knowledge, I am NOT pregnant and the above-named doctor has my permission to x-ray me for diagnostic interpretation.

Signed:_____