PATIENT CONFIDENTIAL INFORMATION

First Name _____ M.I. _____ Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone (Area Code/No.) _____ Work Phone (Area Code/No.) _____ Cell Phone (Area Code/No.) _____

Social Security No. ___-___-___ Birthdate ___/___/___ Age _____ Sex _____ Married _____ Single _____

Your Employer _____ Your Job Title _____

Employer's Street Address _____ City _____ State _____ Zip Code _____ Spouse's Name _____

Spouse's Employer _____ Spouse's Employer's Street Address _____ City _____ State _____ Zip Code _____

E-mail address _____ Nearest relative: _____ (not your spouse) Phone _____

Do you have insurance? ☐ Yes ☐ No If yes, Company:

Automobile Accident Patients: Automobile Insurance Carrier: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that: 1.) This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. 2.) There may be a fee and I will be informed of the amount prior to completion of the forms or reports. 3.) Any amount authorized to be paid directly to this office will be credited to my account upon receipt.

I authorize this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Strauss Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made.

I understand that if it is necessary to refer my account(s) to an outside collection agency, I will be responsible for any additional court costs, attorney fees, and any other collection charges.

In compliance with HIPPA regulations, I have received a copy of Strauss Chiropractic's Privacy Policy. _____ (Initial Here)

I hereby authorize the Doctors of Strauss Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

CONSENT FOR TREATMENT OF A MINOR CHILD

I hereby authorize Dr. _____ and/or whomever he may designate to administer Chiropractic care as deemed necessary

to _____ (Name of Minor), my _____ (Relationship to Minor).

Patient Signature _____ Date _____ / _____ / _____

Consultation

Name _____ Date _____

Please circle Yes or No *Explain*

Have you previously been a patient in this office? (Yes / No) _____

Who referred you? _____

Date of Accident/Injury _____

List major complaint (s) _____

When did you first notice this? _____

Is it worse, AM / PM _____

Any radiation of pain into arms or legs? _____

Is it a sharp or dull pain? _____

Is it constant or does it come & go? _____

Other Dr.'s seen for condition (Yes / No) _____

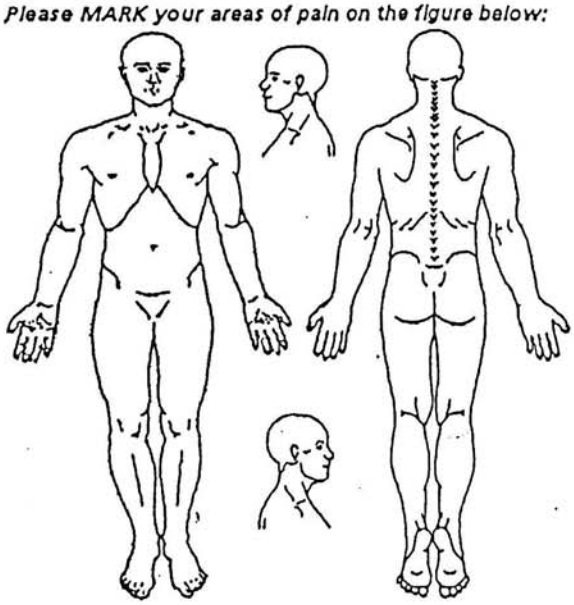
Did anyone recommend surgery? (Yes / No) _____

Any Medication (s) taken for this condition? (Yes / No) _____

Are you on a restrictive diet? (Yes / No) _____

Are you pregnant? (Yes / No) _____

Please MARK your areas of pain on the figure below:



Review of Systems

Please circle Yes or No *Frequency* *Duration*

1) Headaches ..... (Yes / No) _____ _____
2) Dizziness ..... (Yes / No) _____ _____
3) Blurred Vision ..... (Yes / No) _____ _____
4) Buzz/Ring Ears ..... (Yes / No) _____ _____
5) Depression ..... (Yes / No) _____ _____
6) Nervousness ..... (Yes / No) _____ _____
7) Difficulty Sleeping ..... (Yes / No) _____ _____
8) Loss of Energy ..... (Yes / No) _____ _____

Explain

9) Sinuses ..... (Yes / No) _____
10) Neck Pain/Stiff ..... (Yes / No) _____
11) Shoulder Problems ..... (Yes / No) _____
12) Upper Back ..... (Yes / No) _____
13) Mid Back ..... (Yes / No) _____
14) Chest Pain ..... (Yes / No) _____
15) Lung ..... (Yes / No) _____
16) Heart ..... (Yes / No) _____
17) Stomach ..... (Yes / No) _____
18) Constipation ..... (Yes / No) _____
19) Liver ..... (Yes / No) _____
20) Kidney ..... (Yes / No) _____
21) Bladder ..... (Yes / No) _____
22) Low Back ..... (Yes / No) _____
23) Hips ..... (Yes / No) _____
24) Leg Pain/Cramps ..... (Yes / No) _____
25) Poor Circulation ..... (Yes / No) _____
26) Osteoporosis ..... (Yes / No) _____
27) Hyper/Hypo Blood Pressure .... (Yes / No) _____

Previous Injuries

1) Hospitalization/Surgery ..... (Yes / No) _____
2) Accidents/Falls/Auto ..... (Yes / No) _____
3) Accidents on the Job ..... (Yes / No) _____
4) Taking any Medication ..... (Yes / No) _____
5) Family History of Back Problems ..... (Yes / No) _____
6) Have you had Previous Chiropractic Care (Yes / No) _____