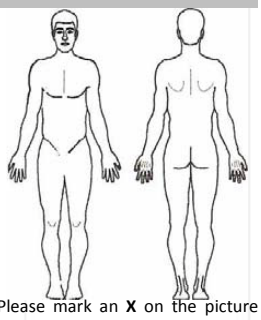
Seto Chiropractic
Patient Information

Personal Information

Full Name: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female Social Security #: _____
Occupation: _____ Employer: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
In Case of Emergency Contact: Name: _____ Relationship: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
How did you hear about Seto Chiropractic? _____

Present Complaint

Reason for today's visit: _____
When did the symptoms first start? _____
Since the complaint started, has it: ☐ Gotten worse ☐ Gotten better ☐ Stayed the same
How would you rate the pain right now? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain ever)
Is the pain: ☐ constant or ☐ does it come and go?
How would you describe the pain? ☐ Sharp ☐ Aching ☐ Dull ☐ Burning ☐ Numbness ☐ Tingling ☐ Other
Does your complaint interfere with: ☐ Work ☐ Sleep ☐ Exercise ☐ Hobbies/Recreation ☐ Daily routine
Activities or movements that are painful: ☐ Walking ☐ Bending ☐ Sitting ☐ Standing ☐ Lying down



Please mark an **X** on the picture where you have pain and/or other symptoms.

Insurance Information

Name of Person Responsible for Account: _____ Relationship to Patient: _____
Auto/Health Insurance: _____ Member #:_____ Group/Claim #: _____
Address: _____
Name of Adjuster: _____ Phone #: ( ) _____
Is the patient covered by additional insurance? ☐ YES ☐ NO
Name of Person Responsible for Account: _____ Relationship to Patient: _____
Other Insurance: _____ Member #:_____ Group/Claim #: _____
Address: _____ Phone #: ( ) _____
Date of Accident: _____ Type of Accident: ☐ Auto ☐ Home ☐ Work ☐ Other_____
Name of Attorney: _____ Phone #: ( ) _____

Assignment and Release

- I, THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE WITH _____ AND ASSIGN ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED DIRECTLY TO SETO CHIROPRACTIC**. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I HEARBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSONS.
- I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. 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.
- **$25 FEE FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS _____(initial)**

_____ _____ _____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

Health History

What treatment(s) have you already received for your condition(s)?
☐ Medication ☐ Surgery ☐ Physical therapy ☐ Chiropractic ☐ None ☐ Other _____
Please list the name and address of other doctors who have treated you for your condition:
_____

Date of last: Physical Exam _____ Spinal Exam _____ Blood Test _____
Spinal X-ray _____ Chest X-ray _____ Other X-ray _____
MRI _____ CT Scan _____ Bone Scan _____

Please mark an X to indicate if you have/had any of the following:

☐ AIDS/HIV	☐ DIABETES	☐ MISCARRIAGE	☐ RHEUMATOID FEVER
☐ ALCOHOLISM	☐ EMPHYSEMA	☐ MONONUCLEOSIS	☐ SCARLET FEVER
☐ ALLERGY SHOTS	☐ EPILEPSY	☐ MULTIPLE SCLEROSIS	☐ STROKE
☐ ANEMIA	☐ FRACTURES	☐ MUMPS	☐ SUDDEN WEIGHT LOSS
☐ ANOREXIA	☐ GLAUCOMA	☐ OSTEOPOROSIS	☐ THYROID PROBLEMS
☐ APPENDICITIS	☐ GOITER	☐ PAIN THAT WAKES YOU UP	☐ TONSILLITIS
☐ ARTHRITIS	☐ HEART DISEASE	AT NIGHT	☐ TUBERCULOSIS
☐ ASTHMA	☐ HEPATITIS	☐ PACEMAKER	☐ TUMORS/GROWTH
☐ BLEEDING DISORDERS	☐ HERNIA	☐ PARKINSON'S DISEASE	☐ TYPHOID FEVER
☐ BREAST LUMP	☐ HERNIATED DISC	☐ PINCHED NERVE	☐ ULCERS
☐ BRONCHITIS	☐ HERPES	☐ PNEUMONIA	☐ VAGINAL INFECTIONS
☐ BULIMIA	☐ HIGH CHOLESTEROL	☐ POLIO	☐ VENEREAL DISEASE
☐ CANCER	☐ KIDNEY DISEASE	☐ PROSTATE CONDITIONS	☐ WHOOPING COUGH
☐ CATARACTS	☐ LIVER DISEASE	☐ PROSTHESIS	☐ OTHER_____
☐ CHEMICAL DEPENDENCY	☐ MEASLES	☐ PSYCHIATRIC CARE	_____
☐ CHICKEN POX	☐ MIGRAINE HEADACHES	☐ RHEUMATOID ARTHRITIS	

Exercise	**Work Activity**	**Habits**
☐ None	☐ Sitting	☐ Smoking Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol Drinks/Week_____
☐ Daily	☐ Light labor	☐ Coffee/caffeine Cups/Day _____
☐ Heavy	☐ Heavy labor	☐ High stress level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Injuries/Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Previous Accidents		

Please list if you are taking any of the following:

Medication	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____