STARKWOOD CHIROPRACTIC

Welcome to Starkwood Chiropractic

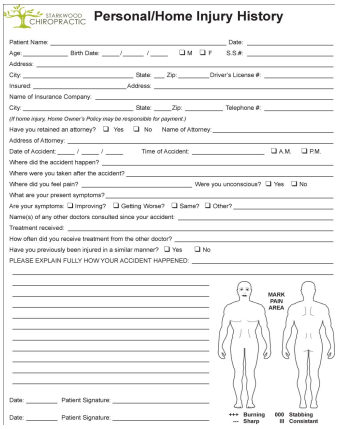
Patient Information

Thank you for choosing Starkwood Chiropractic for your chiropractic needs. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

Name: _____ Date: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Sex: ❑ Female ❑ Male Birthdate: _____ E-mail:_____
Home Phone:(_____)_____ Cell Phone:(_____)_____ Work Phone:(_____)_____
Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference
❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ____ years
Employer/School: _____ Occupation: _____
Person to contact in case of emergency: _____ Phone:(_____)_____
Do you have health insurance? **Y N** If yes, who is your insurance carrier? _____
How did you hear about us? _____

Symptoms

Please mark the diagram where you hurt.
When did your symptoms begin? _____
Did you hurt yourself? **Y N** If yes, how? _____
Have you seen another health care provider for this problem? **Y N**
If yes, who and when? _____
Is the condition getting progressively worse? **Y N**
Which of these activities are difficult to perform? ❑ Sitting ❑ Walking
❑ Standing ❑ Bending ❑ Laying Down ❑ Other
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching
❑ Shooting❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness
How often do you feel the pain? ❑ Constant ❑ Frequent ❑ Occasional


Personal/Home Injury History

Patient Name: _____ Date: _____
Age: _____ Birth Date: ____/____/____ ❑ M ❑ F S.S.#: _____
Address: _____
City: _____ State: ___ Zip: _____ Driver's License #: _____
Insured: _____ Address: _____
Name of Insurance Company: _____
City: _____ State: _____ Zip: _____ Telephone #: _____
(If home injury, Home Owner's Policy may be responsible for payment.)
Have you retained an attorney? ❑ Yes ❑ No Name of Attorney: _____
Address of Attorney: _____
Date of Accident: ____/____/____ Time of Accident: _____ ❑ A.M. ❑ P.M.
Where did the accident happen? _____
Where were you taken after the accident? _____
Where did you feel pain? _____ Were you unconscious? ❑ Yes ❑ No
What are your present symptoms? _____
Are your symptoms: ❑ Improving? ❑ Getting Worse? ❑ Same? ❑ Other? _____
Name(s) of any other doctors consulted since your accident: _____
Treatment received: _____
How often did you receive treatment from the other doctor? _____
Have you previously been injured in a similar manner? ❑ Yes ❑ No
PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED: _____

MARK PAIN AREA

Date: _____ Patient Signature: _____
Date: _____ Patient Signature: _____

*** Burning --- Sharp 000 Stabbing III Consistant

Health History

Please list any medical conditions and diseases from your past to the present (ex: cancer, diabetes, tumors, scarlet fever, etc…): _____
_____
Are you pregnant? **Y N** Are you nursing? **Y N**
List any types of surgeries you have had and approximate dates: _____
_____
Please list all medications you are currently taking: _____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy
Do you smoke? ❑ Yes ❑ No If yes, how much per day? _____
How much liquor do you consume weekly? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Charles Goldston all insurance benefits, if any, otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Charles Goldston may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Signature of Patient or Guardian: _____ **Date:** _____