

Welcome to Bateman-Gatrost Chiropractic!

Date: _____

Account #: _____

Doctor: LWB ALG CAB

Insurance: _____

Patient Information

Last Name: _____ First: _____ Middle: _____

Address: _____ City/State/Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Marital Status: M S D W Sex: Male Female Social Security # _____ - _____ - _____

Date of Birth: ____/____/____ Age: _____ Employment: Full-time Part-Time Student

Occupation: _____ Employer/School: _____

Employer Address: _____ City/State/Zip: _____

Spouse/Parent/Legal Guardian Name: _____ Cell Ph: _____

Spouse/Parent/Legal Guardian Social Security # ____/____/____ Date of Birth: ____/____/____

Spouse/Parent/Legal Guardian Employer: _____

Employer Address: _____ City/State/Zip: _____

Emergency Contact/Nearest Relative not living with you: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Referred to our office by: Name _____ Internet _____ Yellow Pages _____ Other _____

Primary Care Physician _____ PCP Phone: _____

Reason for Visit

Purpose of this visit: _____

When symptoms began: _____

Describe the pain (mark all that apply): Sharp Dull Numbness Tingling Aching Burning Stabbing

Stiffness Throbbing Other, explain: _____

Is there anything you can do to relieve the problem? Yes No

If yes, please describe: _____

If no, what have you tried to do that has not helped? _____

What makes the problem worse? _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

How did it originally occur: _____

Has it become worse lately? Yes No Same Better Gradually Worse If yes, when & how? _____

How frequent is the condition? Constant Daily Intermittent Night time only

How long does it last? All day Few Hours Minutes

CHECK THE SYMPTOMS YOU HAVE NOTICED:

Back Pain
Buzzing in ears
Chest Pain
Constipation
Cold Sweats
Depression
Diarrhea

Dizziness
Face Flushed
Fainting
Fatigue
Feet Cold
Fever
Hands Cold

Headache
Head seems heavy
Hemophilia
Irritability
Lights bother eyes
Loss of Balance
Loss of Memory

Loss of Smell
Loss of Taste
Neck Pain
Neck Stiff
Nervousness
Numbness in Fingers
Numbness in Toes

Pins/Needles in Arms
Pins/Needles in Legs
Shortness of Breath
Sleeping Problems
Stomach Upset
Tension
Other:

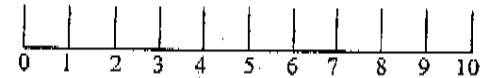
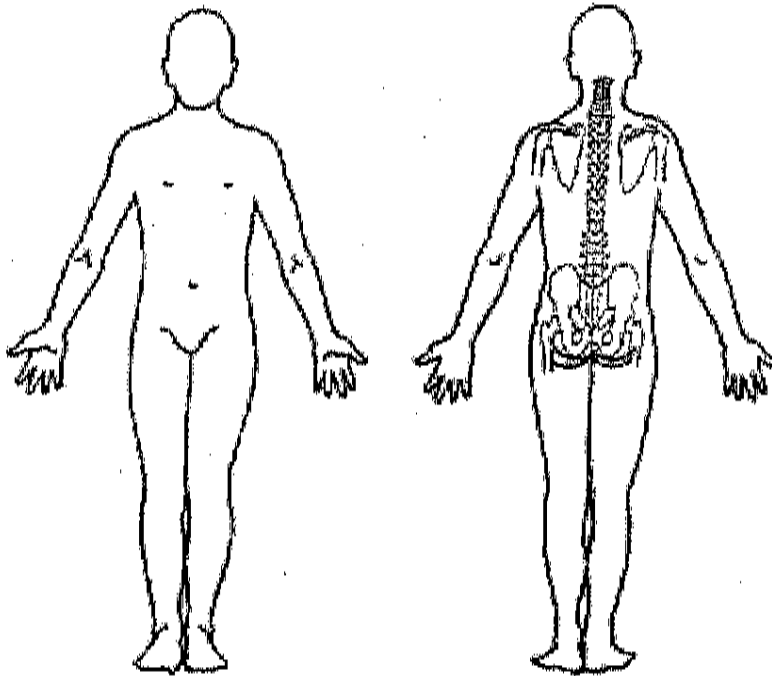
TODAY I feel:

About the same Somewhat improved Much improved No more complaints Other, explain: _____

Pain Chart

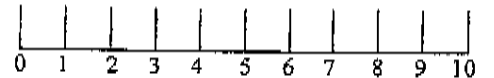
0 = No pain / 5 = Medium pain / 10 = Severe pain

Circle areas of discomfort on figures



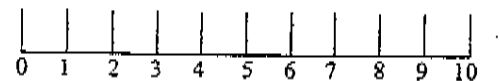
Neck-Shoulder-Arm Pain

On a scale of zero to 10, I rate my discomfort as follows:



Mid-Back Pain

On a scale of zero to 10, I rate my discomfort as follows:



Low-Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

Authorization and Acknowledgement

The above questions have been accurately answered. I authorize Bateman-Gatrost Chiropractic, P.C. to release any information, including the diagnosis and records of any treatment or examination rendered to myself or my dependents, during the period of such chiropractic care to my attorney/third-party payor/insurance carrier and/or health practitioners for the payment of claims or for continuity of care. I authorize and request my attorney/third-party payor and or insurance carrier to pay directly to Bateman-Gatrost Chiropractic, P.C. benefits otherwise payable to me. I understand that my attorney/third-party payor and/or insurance carrier may pay less than the actual bill for services and that I shall be responsible for the remaining balance within 30 days.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MY DEPENDENTS.

Patient Signature / Parent or Legal Guardian of Minor

Date

Parent or Legal Guardian of Minor - Please Print Name

Relationship

Bateman-Gatrost Chiropractic, P.C.

Date: _____

Doctor: LWB ALG CAB

Patient Name: _____

Account # _____

Medical History

List any medications, supplements, vitamins, herbs, minerals, etc. you are currently taking: _____

List any allergies to medication: _____

Have you had surgery? Yes No If yes, please list date and type of all surgeries.

Date

Surgery

_____	_____
_____	_____
_____	_____

Have you had any serious illness? Yes No If yes, please list date and type: _____

Childhood diseases: Chicken Pox Measles Mumps Any unusual diseases? Yes No

If yes, please list date and type: _____

Have you had any broken bones? Yes No If yes, please list and give dates: _____

How many ounces of liquid do you consume on a daily basis? _____ Water _____ Coffee _____ Soda _____ Alcohol _____ Other _____

Please check all symptoms and/or conditions that you have experienced:

Arthritis	Fatigue	Joint Pain/Swelling	Ringing in Ears
Artificial Bone/Joint	Feet Cold	Kidney Stones	Shoulder/Arm Pain
Back Pain	Fever	Lights Bother Eyes	Sinus Problems
Breathing Problems	Frequent Colds	Loss of Balance	Sleeping Problems
Blood Disorders	Hands Cold	Loss of Memory	Stiff Neck
Bruise Easily	Headaches	Loss of Smell	Stroke / TIA
Cancer	Heart Attack	Loss of Taste	Tension
Carpal Tunnel	Hemophilia	Menstrual Problems	Thyroid
Chest Pain/Tightness	Herniated Disc	Muscle Spasms	Weakness
Depression	High Blood Pressure	Neck Pain	Weight Gain
Diabetes I/II	Hysterectomy	Nervousness	Weight Loss
Difficulty Urinating	Indigestion	Numbness	Other - Specify *
Dizziness	Irritability	Pinched Nerve(s)	*
Fainting	Jaw Pain	Prosthesis	

Have you seen a Chiropractor before? Yes No If yes, list name of doctor and date(s): _____

Did the treatment received help your condition? Yes No

What condition were you treated for? _____

How long were you treated? _____

Family History

Please review the diseases and conditions listed below and indicate those that are current health problems of the family member listed. Leave those spaces blank that do not apply. Circle your answers if your relatives live around this locality, as some hereditary conditions are affected by similar climate.

CONDITIONS:	FATHER	MOTHER	BROTHER(S)	SISTER(S)	SPOUSE	CHILDREN
Age						
Living or Deceased						
Arthritis						
Asthma / Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Emphysema						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve(s)						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Thyroid						
Other:						

Remarks / Other Medical Information: _____

Social History

Please indicate beside each activity whether you engage in it:

O = OFTEN

S = SOMETIMES

N = NEVER

Vigorous Exercise	Alcohol Use	Caffeine	Financial Pressures
Moderate Exercise	Drug Use	High Stress Activity	Other Mental Stress
Daily Exercise	Tobacco Use	Family Pressures	Other - Specify *

FOR WOMEN ONLY:

Are your menstrual cycles? Regular Irregular Normal Light Heavy Painful

Are you pregnant or is there a possibility you may be pregnant? Yes No Uncertain

If yes, due date: _____

FOR OFFICE USE ONLY

Doctor's Notes: _____

Welcome to Bateman-Gatrost Chiropractic!

Date: _____

Personal Injury Account #: _____

Doctor: LWB ALG CAB

Patient Information

Last Name: _____ First: _____ Middle: _____

Address: _____ City/State/Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Marital Status: M S D W Sex: Male Female Social Security # _____ - _____ - _____

Date of Birth: ____/____/____ Age: _____ Employment: Full-time Part-Time Student

Occupation: _____ Employer/School: _____

Employer Address: _____ City/State/Zip: _____

Spouse/Parent/Legal Guardian Name: _____ Cell Ph: _____

Spouse/Parent/Legal Guardian Social Security # ____/____/____ Date of Birth: ____/____/____

Spouse/Parent/Legal Guardian Employer: _____

Employer Address: _____ City/State/Zip: _____

Emergency Contact/Nearest Relative not living with you: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Reason for Visit

Purpose of this visit: Auto accident Slip/Fall Other: _____ In what State did this occur? _____

Date/Time of incident: _____ Were you: Driver Passenger Front Seat Back Seat

Wearing a seatbelt? Yes No Were you knocked unconscious? Yes No If yes, how long: _____

Where was the impact? Behind Front Driver's Side Passenger's Side Did airbag deploy? Yes No

In your own words, please describe the incident: _____

Did you have any physical complaints prior to the incident? Yes No If yes, please describe: _____

Please describe your complaints and symptoms since the incident: _____

Please list any activities of daily living or demands of employment that you could perform prior to the incident that you are unable to perform since the incident: _____

Describe the pain (mark all that apply): Sharp Dull Numbness Tingling Aching Burning Stabbing
 Stiffness Throbbing Other, explain: _____

What makes the problem worse? _____

Is there anything you can do to relieve the problem? Yes No

If yes, please describe: _____

If no, what have you tried that has not helped: _____

Has it become worse lately? Yes No Same Better Gradually Worse If yes, when & how? _____

How frequent is the condition? Constant Daily Intermittent Night time only

How long does it last? All day Few Hours Minutes

CHECK ALL SYMPTOMS SINCE THE ACCIDENT:

Back Pain	Dizziness	Headache	Loss of Smell	Pins/Needles in Arms
Buzzing in ears	Face Flushed	Head seems heavy	Loss of Taste	Pins/Needles in Legs
Chest Pain	Fainting	Hemophilia	Neck Pain	Shortness of Breath
Constipation	Fatigue	Irritability	Neck Stiff	Sleeping Problems
Cold Sweats	Feet Cold	Lights bother eyes	Nervousness	Stomach Upset
Depression	Fever	Loss of Balance	Numbness in Fingers	Tension
Diarrhea	Hands Cold	Loss of Memory	Numbness in Toes	Other:

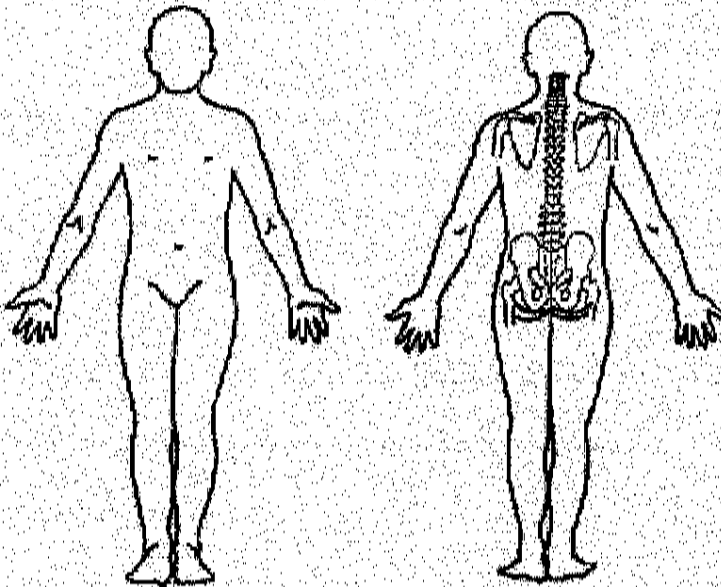
Since the accident, TODAY I feel:

About the same Somewhat improved Much improved No more complaints Other, explain: _____

Pain Chart

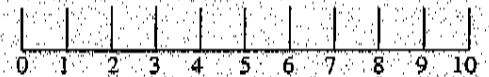
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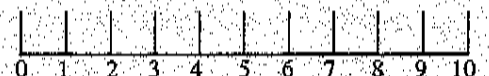
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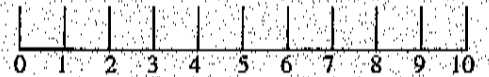
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