

Welcome to Bateman-Gatrost Chiropractic!

Date: _____

Account #: _____

Doctor: **LWB** ALG CAB DAB

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: _____

How were you referred to our office? _____

Primary Care Physician? _____ PCP Phone: _____

Reason for Visit

Purpose of this visit: _____

Date 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	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:

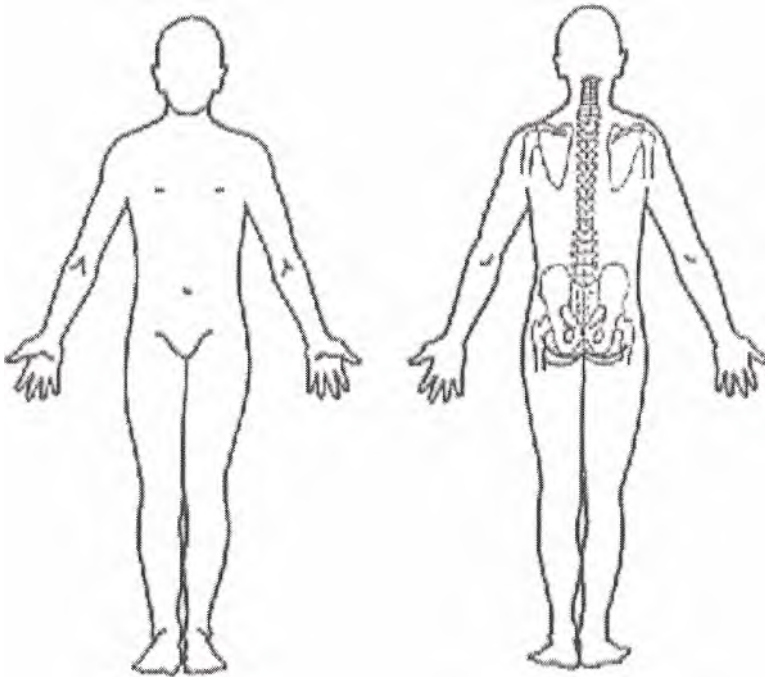
TODAY I feel:

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

Pain Chart

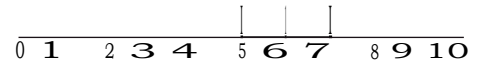
0 = No pain / 5 = Medium pain / 10 = Severe pain

Circle areas of discomfort on figures



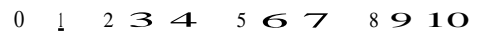
Neck-Shoulder-Arm Pain

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

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: _____

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:						

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 *

Remarks / Other Medical Information: _____

FOR OFFICE USE ONLY

Doctor's Notes: _____

