DATE_____

HISTORY QUESTIONAIRE

By signing this form I give this office or their representatives permission to contact me buy Cell, work or home phone. Cell#_____

NAME _____ WORK PH#_____HM. PH#_____

ADDRESS_____CITY_____ST._____ZIP_____

MARITAL STATUS_____DRIVERS LICENSE#_____ SS#_____ BIRTHDAY_____

SPOUSE OR PERSON TO CONTACT FOR AN EMERGENCY_____ PH.#_____

REFERRED BY WHOM_____, YELLOW BOOK YELLOW PAGES_____

BELL SOUTH REAL YELLOW PAGES_____ OUR SIGN_____, OTHER_____

YOUR HEALTH INSURANCE_____ GROUP#_____ID#_____

SPOUSE'S HEALTH INSURANCE_____ GROUP#_____ ID#_____

YOUR AUTO INSURANCE_____ POLICY#_____ PHONE_____

METHOD OF PAYMENT FOR SERVICES: CHECK_____ MASTER, DISCOVER, VISACARD_____ AM.EXPRESS_____

YOUR OCCUPATION:_____ EMPLOYER _____

PRESENT ILLNESS OR INJURY: **Your E-Mail For News Letters_____**

PLEASE DESCRIBE YOUR PRIMARY PROBLEM AND DATE IT OCCURRED_____

_____

IS THIS PROBLEM GETTING WORSE, SAME OR BETTER_____

DOES THIS IMPACT YOUR WORK?, RECREATION?, HOME LIFE?, RELATIONSHIPS?..., IF SO, HOW _____

_____

ARE YOUR PROBLEMS RELATED TO AN INJURY, IF SO BRIEFLY DESCRIBE WHAT HAPPENED, auto?, work?,

home?, or other accident. We will get more details later on other the paperwork_____

Do you exercise?_____ What kind?_____

Do you take vitamins / minerals etc… _____

Family History (please mark all items that apply to your blood relatives)

Diabetes _____Hypertension _____Heart Disease _____High Cholesterol _____ Seizures _____Strokes _____ Migraines _____Ulcers ____

Depression _____ Aids ____Cancer /Type_____ Other_____

MY SYMPTOMS ARE BEST DESCRIBED AS FOLLOWS: (circle and check appropriate answers)

ACHE | SHARP/ STAB | THROBBING | BURNING | NUMBNESS | WEAKNESS | MUSCLE SPASM | STIFFNESS

**\ \ \ \ \ \ \ **

A S T B N W M ST

HEAD =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**	**THE FOLLOWING ACCOMPANIES**
NECK =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**	**MY OTHER SYMPTOMS**
MID-BACK =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**	**___ CRAVE SALTY FOODS**
LOW BACK =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**	**___ RINGING IN THE EARS**

Continue to next page

ACHE | SHARP/ STAB | THROBBING | BURNING | NUMBNESS | WEAKNESS | MUSCLE SPASM | STIFFNESS
**\ \ \ \ \ \ \ **
A S T B N W M ST

LT. RT. SHOULDER =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**
LT. RT. ARM =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**
LT. RT. ELBOW =	**A**	**S**	**T**	**B**	**N**	**W**		**ST**
LT. RT. WRIST =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**
LT. RT. FINGERS =	**A**	**S**	**T**	**B**	**N**	**W**		**ST**
LT. RT. HIP =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**
LT. RT. KNEE =	**A**	**S**	**T**	**B**	**N**	**W**		**ST**
LT. RT. LEG =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**
LT. RT. ANKLE =	**A**	**S**	**T**	**B**	**N**	**W**		**ST**
LT. RT. TOES =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	**ST**
CHEST =	**A**	**S**	**T**	**B**	**N**	**W**	**M**	
LT. RT. RIB =	**A**	**S**	**T**	**B**	**N**		**M**	

___ BLURRING OF VISION
___ DIZZINESS, FAINTING
___ LOSS OF BALANCE
___ LOSS OF TASTE, SMELL
___ LOSS OF HEARING
___ LOSS OF MEMORY
___ LIGHT BOTHERS EYES
___SWALLOW PROBLEMS
___ FATIGUED OFTEN
___ DEPRESSION
___ LOSS OF WEIGHT
___ LOSS OF SLEEP

SYMPTOMS INCREASE WITH: SITTING ___STANDING ___LYING ___ BENDING ___STOOPING ___LIFTING ___

COUGH/SNEEZE ___WORKING HANDS OVER HEAD___ OTHER? _deep massage, etc…_____

OTHER SYMPTOMS OR PERTINENT INFORMATION: popping, grinding sensations, etc..._____

_____

INSURANCE:

I the undersigned, have insurance and assign directly to Dr. Kenneth W. Mitchell all medical and/or government benefits, if any, payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I understand that filing and waiting for payment from my insurance company is a courtesy. I understand that this office allows 60 days for payment of insurance claims, and that my co-pay percent, deductible and services not covered by insurance, if applicable, are due and payable when services are rendered or when you receive your portion on an estimation of benefits from you insurance company or with the first billing from this office following insurance reimbursement. (We do not monthly bill patients)

I further understand that my insurance is a contract between myself and my insurance carrier, and not with Mitchell Chiropractic Clinic and the insurance company. I understand I am responsible for any negotiations with my carrier for unpaid claims, not Mitchell Chiropractic Clinic, and that I may be billed after 90 days. I further agree that I am responsible for any unpaid balance, relating to treatment for any vehicular, personal or work related injury.

CASH AND INSURANCE:

I understand that I am responsible for all collection fees, including annual interest on delinquent balances, plus attorney, court cost fees and collection agency fees, should this become necessary. The above questions have been answered truthfully and to the best of my knowledge. I realize that Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: To locate, analyze and correct spinal interference to the nerve and muscular system. I do realize that any medical procedure is not without some minimal risks, I give my consent for evaluation and or treatment with my signature.

SIGNATURE:_____ DATE:_____
Patient or Guardian, if patient is a minor

If patient is a minor, I hereby as guardian give my consent and permission for evaluation and or treatment in this office, and I furthermore agree to the above aforementioned with my signature above.

ADDITIONAL INFORMATION FOR A PERSONAL INJURY

(PLEASE FILL OUT APPROPRIATE SECTIONS ONLY)

***** IF AN AUTOMOBILE ACCIDENT***:**

WERE YOU ( ) DRIVER ( ) PASSENGER ( ) FRONT SEAT ( ) BACK SEAT

WERE YOU WEARING YOUR SEAT BELT ? _____, NUMBER OF PEOPLE IN VEHICLE _____.

WERE YOU STRUCK FROM ( ) BEHIND ( ) FRONT ( ) LEFT SIDE ( ) RIGHT SIDE ( ) OTHER

APPROXIMATE SPEED OF YOUR VEHICLE ? _____, WAS OTHER VEHICLE MOVING ? _____.

DID AIRBAG DEPLOY ? _____. WERE POLICE NOTIFIED ? _____.

WERE YOU TREATED AT THE SCENE BY E.M.T'S OR TAKEN TO A HOSPITAL BY AMBULANCE ? _____.

WERE YOU KNOCKED UNCONSCIOUS ? _____, IF SO FOR HOW LONG ? _____.

*****IF A WORK RELATED ACCIDENT***:**

DESCRIBE THE ACCIDENT: _____

_____

_____

WAS YOUR EMPLOYER NOTIFIED OF YOUR INJURIES ?_____. WAS AN ACCIDENT REPORT FILED ? _____.

WERE THEIR ANY WITNESSES ? _____. WERE YOU TREATED AT THE SCENE BY A COMPANY NURSE OR

DOCTOR? IF SO WHO_____. WERE YOU TAKEN TO A HOSPITAL BY AMBULANCE? _____.

WERE YOU KNOCKED UNCONSCIOUS ? _____, IF SO FOR HOW LONG ? _____.

***** IN EITHER CASE, WORK OR AUTO RELATED*****

HAVE YOU BEEN TREATED IN AN EMERGENCY ROOM OR DOCTORS OFFICE SINCE THE ACCIDENT _____.

IF SO WHERE & WHEN _____

_____

TYPE OF TREATMENT RECEIVED AND FOR HOW LONG:_____

_____

PLEASE DESCRIBE HOW YOU FELT IMMEDIATELY AFTER THE ACCIDENT _____

_____

LATER THAT DAY ? _____

_____

THE NEXT DAY ? _____

_____

SINCE THIS ACCIDENT, ARE YOUR SYMPTOMS ( ) IMPROVING ( ) GETTING WORSE ( ) THE SAME

DO YOU HAVE ANY PREVIOUS ILLNESSES OR INJURIES THAT AFFECT YOUR PRESENT INJURIES ? _____

IF SO PLEASE DESCRIBE: _____

PRIOR TO THIS ACCIDENT HAVE YOU EVER HAD ANY OF THE PHYSICAL COMPLAINTS SIMILAR TO WHAT YOU HAVE NOW ? , IF SO DESCRIBE THEM: _____

_____

HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE ? _____, IF SO PLEASE DESCRIBE AND GIVE DATES OF OCCURRENCE _____

HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT ( ) YES ( ) NO

IF YES ARE YOU BEING COMPENSATED FOR YOUR LOST TIME ( ) YES ( ) NO

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT ( ) YES ( ) NO. IF SO TO WHAT CAPACITY.

( ) REGULAR DUTY ( ) LIGHT DUTY ; AND ( ) FULL TIME ( ) PART TIME. IF NOT, WHAT TYPE OF WORK ARE YOU ABLE TO DO?_____

AND ARE YOU PLANNING TO RETURN TO YOUR REGULAR JOB IN THE FUTURE_____

HAVE YOU RETAINED AN ATTORNEY ON YOUR BEHALF ( ) YES ( ) NO. IF SO WHO _____

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS ACCIDENT ( ) YES ( ) NO. IF SO DESCRIBE IN DETAIL: _____

_____

_____

_____

ARE YOU TAKING ANY MEDICATIONS TODAY, IF SO PLEASE LIST THEM_____

ON A SCALE OF 0 TO 10, WITH 0 BEING NO PAIN, AND 10 BEING THE WORST PAIN, WHERE WOULD YOU RATE YOUR PAIN RIGHT NOW_____

PATIENT SIGNATURE_____ DATE:_____

PLEASE COMPLETE THE FUNCTIONAL RATING INDEX ON THE FOLLOWING INTERANCE TO THE OFFICE AND GIVE THESE FORMS BACK TO OUR FRONT DESK PERSONEL