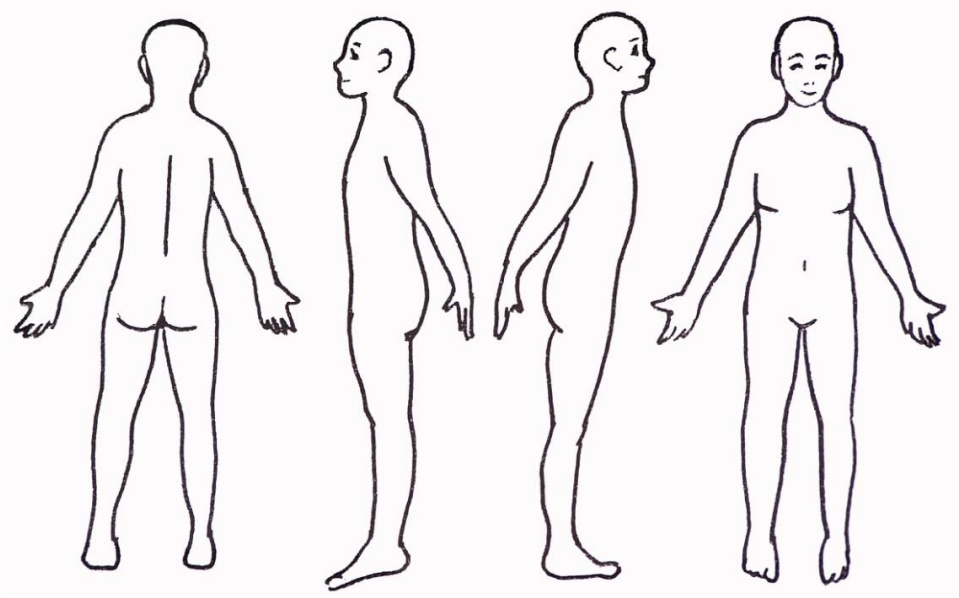
Patient Name: _____ Date:_____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing 0 = Pins and Needles + = Dull Ache



Please describe your condition: _____

_____

_____

When did this problem start? Month _____ Day _____ Year_____

What caused this problem (accident / injury / incident)?_____ _____

_____

What percentage of the day do you experience your symptoms?

❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%

What describes the nature of your symptoms? (Choose any that apply)

❒ Sharp	❒ Dull Ache	❒ Numb	❒ Shooting	❒ Cramping
❒ Burning	❒ Stabbing	❒ Tingling	❒ Throbbing	❒ Deep

Other:_____

How are your symptoms changing? ❒ Getting better ❒ Not changing ❒ Getting worse

Please indicate the intensity of your symptoms: (0 = No pain, 10 = Unbearable pain)

No Pain											**Unbearable Pain**
❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Are your symptoms worse ❒ in the morning ❒ by midday ❒ throughout the day ❒ at the end of the day ❒ during the night

Does anything relieve your symptoms?

❒ sitting	❒ standing	❒ lying down	❒ medication	❒ rest
❒ ice	❒ heat	❒ stretching	❒ movement	❒ no movement

Other:_____

Patient Name: _____ Date:_____

Who have you seen for this problem? ❒No one ❒Other chiropractor ❒Medical Doctor ❒Physical Therapist
Name of physician or therapist: _____

What treatment did you receive for your symptoms?
❒Adjustments ❒Physical Therapy ❒Medication ❒Surgery ❒Other: _____

When did you receive this treatment?
❒In the last month ❒2-3 months ago ❒3-6 months ago ❒6 months to 1 year ago
❒1-2 years ago ❒2-5 years ago ❒5-10 years ago

What tests have you had for your symptoms? ❒X-rays ❒MRI ❒CT Scan ❒Other_____

When were these tests done?
❒In the last month ❒2-3 months ago ❒3-6 months ago ❒6 months to 1 year ago
❒1-2 years ago ❒2-5 years ago ❒5-10 years ago

Have you had an X-ray, or CT scan or MRI of your low back spine in the last 28 days? ❑ Yes ❑ No

Have you had similar symptoms in the past? ❒Yes ❒No

If you have been seen for treatment in the past for same or similar symptoms, who did you see?
❒This office ❒Other chiropractor ❒Medical Doctor ❒Physical Therapist
❒Other Name of physician: _____

In general, would you say your overall health right now is: ❒Excellent ❒Very good ❒Good ❒Fair ❒Poor

Your height: _____ ft. _____inches Your weight: _____lbs Are you: ❒Right handed ❒Left handed

Who is your primary care physician? _____ Location: _____

FEMALE PATIENTS: To your knowledge, are you pregnant? ❒No ❒Yes Date of last period _____

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT

How will you pay for today's visit? ❒Cash ❒Check ❒MasterCard ❒VISA ❒Discover ❒American Express

Are you insured? ❒Yes ❒No Insured's name, if other than yourself: _____

Insured's date of birth: _____ Relation: _____ Insured's Employer: _____

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST SO WE MAY COPY THEM FOR YOUR RECORDS

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for all charges, whether or not they are paid by my insurance. I clearly understand and agree that there is no guarantee that my health insurance will pay for all or part of my care. I hereby authorize my insurance benefits be paid directly to Christopher A. Carraway, D.C., realizing I am responsible to pay for any co-insurance, co-payments, deductibles and non-covered services, and I authorize the use of this signature on all insurance submissions. I hereby grant permission to Dr. Carraway and his staff to perform any necessary services needed for the diagnosis and treatment of my condition. I hereby authorize the release of any and all necessary health information to insurance carriers, attorneys, employers, and other physicians, or any other necessary parties for the purpose of treatment, payment, and healthcare operations. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature: _____ _____Date_____

Parent or Guardian's Signature Authorizing Care for Minor Child: _____Date_____