Patient Information

Date _____

SS # _____

Patient Name

_____

Address

_____

E-mail

_____

City

_____

State Zip

_____ _____

Cell Phone (____) _____

Home Phone (___) _____

Best Place and time to reach you_____

In Case of Emergency, contact

Name_____

Relationship_____

Home Phone (____) _____

Work Phone (____) _____

Sex □M □F Age _____

Birth date _____

□Married □Widowed □ Single

□Minor □ Separated □ Divorced

□Partnered for _____years

Patient

Employer/School_____

Occupation _____

Employer/School Address

_____

Employer/School Phone (___) _____

Spouse's Name_____

Birth date_____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

Is this condition due to an accident?

□ Yes □No Date_____

Type of Accident □ Auto □ Work

□ Home □ Other

To whom you made a report of your accident? □ Auto Insurance

□ Employer □ Worker Comp □ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for visit_____

When did your symptoms appear?

_____

Is this condition getting progressively worse? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

_____

Type of pain: □Sharp □Dull

□Throbbing □Numbness □Aching

□Shooting □Burning □Tingling

□Cramps □Stiffness □Swelling

□ Other

How often do you have this pain?

_____

Is it constant or does it come and go?

_____

Does it interfere with your □Work

□Sleep □Daily Routine □Recreation

Activities or movements that are painful to perform: □ Sitting □Standing

□Walking □ Bending □ Lying Down

What treatment have you already received for your condition? □ Medication □Surgery □Physical Therapy □Chiropractic Services □None □Other

Name and address of other doctor(s) who have treated you for your condition_____

Date of Last: Physical Exam _____ Spinal X-ray_____
Blood Test_____ Spinal Exam _____
Chest X-ray _____ Urine Test_____
Dental X-ray _____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□Yes □No	Measles	□Yes □No
		Migraine Headaches	□Yes □No
Alcoholism	□Yes □No	Miscarriage	□Yes □No
Allergy Shots	□Yes □No	Mononucleosis	□Yes □No
Anemia	□Yes □No	Multiple Sclerosis	□Yes □No
Anorexia	□Yes □No	Mumps	□Yes □No
Appendicitis	□Yes □No	Osteoporosis	□Yes □No
Arthritis	□Yes □No	Pacemaker	□Yes □No
Asthma	□Yes □No	Parkinson's Disease	□Yes □No
Bleeding Disorders	□Yes □No	Pinched Nerve	□Yes □No
Breast Lump	□Yes □No	Pneumonia	□Yes □No
Bronchitis	□Yes □No	Polio	□Yes □No
Bulimia	□Yes □No	Prostate Problem	□Yes □No
Cancer	□Yes □No	Prosthesis	□Yes □No
Cataracts	□Yes □No	Psychiatric Care	□Yes □No
Chemical Dependency	□Yes □No	Rheumatoid Arthritis	□Yes □No
Chicken Pox	□Yes □No	Rheumatic Fever	□Yes □No
Diabetes	□Yes □No	Scarlet Fever	□Yes □No
Emphysema	□Yes □No	Sexually Transmitted Disease	□Yes □No
Epilepsy	□Yes □No	Stroke	□Yes □No
Fractures	□Yes □No	Suicide Attempt	□Yes □No
Glaucoma	□Yes □No	Thyroid Problems	□Yes □No
Goiter	□Yes □No	Tonsilitis	□Yes □No
Gonorrhea	□Yes □No	Tuberculosis	□Yes □No
Gout	□Yes □No	Tumors, Growths	□Yes □No
Heart Disease	□Yes □No	Typhoid Fever	□Yes □No
Hepatitis	□Yes □No	Ulcers	□Yes □No
Hernia	□Yes □No	Vaginal Infections	□Yes □No
Herniated Disk	□Yes □No	Whooping Cough	□Yes □No
Herpes	□Yes □No	Other _____	
High Blood Pressure	□Yes □No	_____	
High Cholesterol	□Yes □No		
Kidney Disease	□Yes □No		
Liver Disease	□Yes □No		

Exercise:
□None □Moderate □Daily □Heavy

Work Activity:
□ Sitting □Standing □Light Labor □Heavy Labor

Habits:
□ Smoking Packs/Day _____
□ Alcohol Drinks/Week_____
□ Coffee/Caffeine Drinks Cups/day_____
□ High Stress Level Reason_____

Are you pregnant? □Yes □No Due Date_____

Injuries/ Surgeries you have had:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name_____
Pharmacy Phone (____)_____

Insurance Information

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____ Group # _____
Is patient covered by additional insurance? □Yes □No
Subscriber's Name _____
Birthdate_____ SS # _____
Relationship to the Patient _____
Insurance Co. _____ Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Scharenberg all insurance
(Name of Insurance Company(ies)
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.

The above-named doctor 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 payable for related services. This consent will end when my current treatment plan is completed or one year for the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient