Describe your current problem and how it began:

Other Complaints:

How Long have you had this condition _____ Days Weeks Months Years
Have you had this or similar condition in the past? Yes No
What activities aggravate your condition?

Is condition getting progressively worse? Yes No Constant Comes and Goes
Is condition interfering with your: Work Sleep Daily Routine Exercise Hobbies
How long has it been since you felt really good?

Current complaint (how you feel today):
No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
How often are your symptoms present?: 25% 50% 75% 100% of the time

Please check the boxes that correspond to the symptoms you are experiencing.

☐ low back pain	☐ sciatica	☐ tension
☐ numbness in legs/feet	☐ mid back pain	☐ fatigue
☐ tingling in legs/feet	☐ knee/ankle pain R/L	☐ irritability
☐ neck pain	☐ elbow/wrist pain R/L	☐ depression
☐ headaches	☐ weakness	☐ shortness of breathe
☐ shoulder pain R/L	☐ constipation	☐ buzzing or ringing in ears
☐ numbness in arms/hands	☐ diarrhea	☐ dizziness
☐ tingling in arms/hands	☐ sleeping problems	☐ sinus problems

Have you ever suffered from:	☐ Anemia	☐ Cancer	☐ heart trouble
	☐ Arthritis	☐ Diabetes	☐ sinus trouble
	☐ Asthma	☐ Digestive disorders	☐ Tuberculosis

Payment is expected at time of visit!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's staff will submit claims and assist me in collecting from the insurance company.

I authorize the insurance company to pay the doctor directly, and that such amounts will be credited to my personal account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I further agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may charge a late fee of $15 per month, and in event of default, I agree to pay reasonable collection charges and/or attorney fees.

I authorize the release of any information necessary to process this claim and payment of medical benefits directly to the doctor for services rendered.

Patient's Signature _____ Date _____