"We've got your back!"

North Idaho Spine Clinic

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265-BACK (2225)

Welcome!

About you ***** PLEASE PRINT *****

Today's date: _____/_____/_____

Name:_____

Nickname you prefer to be called:_____

☐ Male ☐ Female

Birthdate:_____ Age:_____

Social security #: _____

Mailing address: _____

_____
City State Zip

Home phone #:_____

Cell phone#:_____

Work phone#:_____

Referred by: _____

Employer:_____Occupation_____

Email:_____

Marital status: ☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed ☐ Partner

Spouse's name:_____

Health history

Are you taking any of the following medications?

☐ Pain killers (including aspirin)

☐ Muscle relaxers ☐ Stimulants ☐ Insulin

☐ Blood thinners ☐ Tranquilizers

Other(s):_____

Do you smoke? ☐ No ☐ Yes/how long?_____

How much? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts

☐ Inner soles ☐ Arch supports

What is the age of your mattress?_____

Is it comfortable? ☐ Yes ☐ No

What is your current weight? _____lbs.

What is your height? _____ft. _____in.

Do you have a pacemaker? ☐ Yes ☐ No

For Women:

Are you taking Birth Control? ☐ NO ☐ YES

Are you pregnant? ☐ No ☐ Yes/due date?_____

Nursing? ☐ NO ☐ YES Weeks Along?_____

Reason for visit

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, please explain:_____

The reason for this visit is a result of *(please circle)*: work sports auto trauma chronic

Please explain what happened:_____

_____

Please describe the pain and its location:_____

_____

When did condition begin? _____/_____/_____

Is the condition getting worse? ☐ Yes ☐ No

Is this condition interfering with your *(please circle)*: work sleep daily routine

If so, please explain:_____

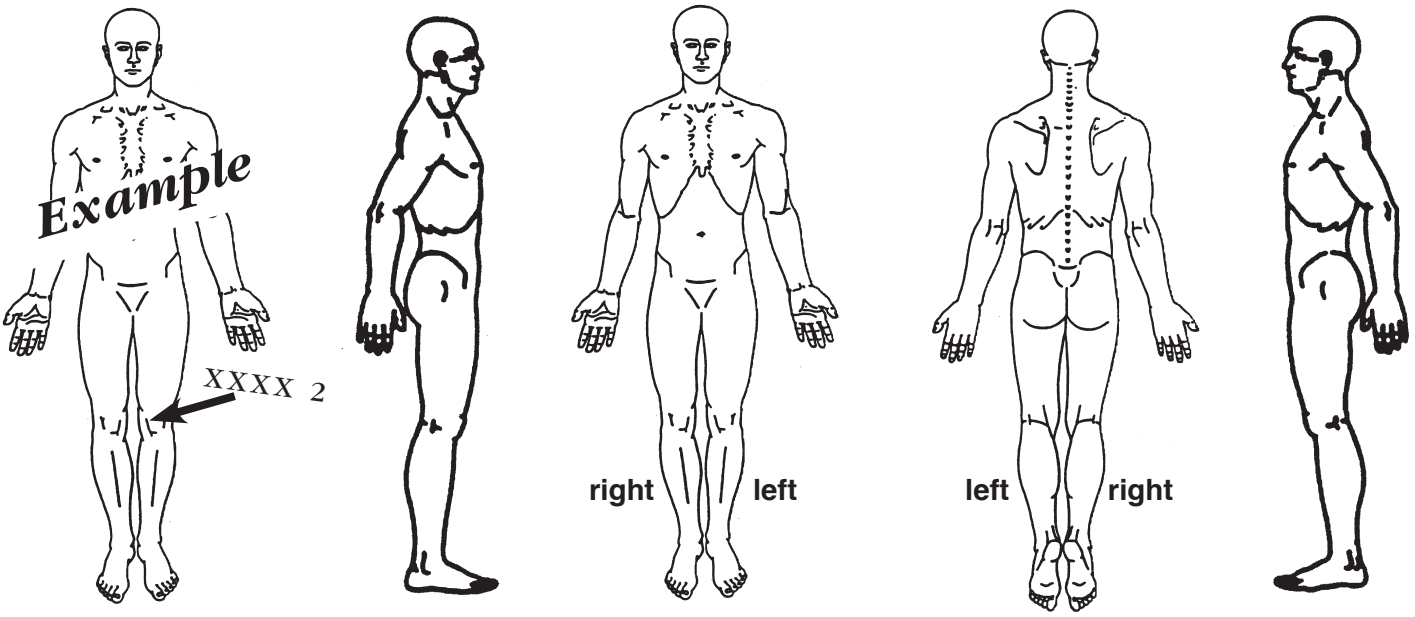
Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where:_____

Show us where it hurts

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (DISCOMFORT) to 10 (EXTREME PAIN).

Numbness ———— Pins & Needles OOOOO Burning ~~~~~ Aching XXXXX Stabbing •••••



Example Right Front Back Left

Policies

■ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

■ In consideration of other patients' needs, if you are unable to keep your appointment, we request that you call 12-24 hours before your appointment to notify us of the change in your schedule. Other patients may need this time. *(Failure to notify us may result in a missed appointment charge).*

■ Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. If the account is not paid and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

■ Our office only accepts Medicare insurance and Workman's comp/Personal Injury claims. If applicable, I hereby authorize assignment of my insurance rights and benefits directly to provider for services rendered.

■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ **Date:** _____/_____/_____