CONFIDENTIAL PATIENT INFORMATION

Name ______________________________ Birth Date ______________

Address ______________________________ Soc. Sec. Num ______________

City/State/Zip ______________________________ Phone: Home ______________

Marital Status M W S D How many children __________ Work ______________

Referred by ______________ E-mail ______________ Cell ______________

Occupation ______________________ Employer ______________________

Employer's Address ____

Spouse's Name ______________ Soc. Sec. No. ______________ Birth Date __________

Employer ______________________ Address ______________________

If accident, how did it occur? ____

____

Date of Accident __________ Time of Day __________ Location ______________

Have you lost time from work due to this injury: YES NO If yes, dates ______________

Are you insured? YES NO Name of Company ______________________

Medicare? YES NO Medicare Supplement? Name of Company ______________

INSURANCE ASSIGNMENT: I have insurance and will make assignment to the doctor and/or clinic.

My deductible is ______________ I have met my deductible for the current year. YES NO

I will pay the deductible in full. After the deductible has been met I will pay my percentage of services rendered at the end of each week. I will also pay any amount not covered by my insurance policy(s). The doctor and / or clinic shall receive the checks from my insurance carrier, and inform me of the amount due, I shall pay the balance in full. If the insurance check is not issued within thirty (30) days, I understand that it is my responsibility to make payment on the unpaid balance. Reductions and rejections of claims by the insurance carrier, I understand, do not in any way affect my obligation to pay the bill in full.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Shows Office will prepare any necessary reports and forms to assist me in making collection from the insurance company. I also understand that if I suspend or terminate my care and treatment; fees for professional services rendered me will be immediately due and payable.

I hereby give permission for Dr. Wm. Michael Shows to provide information concerning his examination findings, diagnosis, treatment or prognosis as may be requested by an insurance company or attorney.

I hereby authorize payment directly to Dr. Wm. Michael Shows for professional services rendered.

A photographic copy of this authorization is as valid as the original.

A FINANCE CHARGE will be imposed on all 30 day past due accounts. The FINANCE CHARGE is computed by a periodic rate of 1 1/2% per month which is an ANNUAL PERCENTAGE RATE OF 18%. Please pay within the allowed time to avoid any FINANCE CHARGE.

Patient's Signature ______________________________ Date ______________

CONSENT TO TREAT MINOR CHILD: I hereby authorize the Doctor to administer chiropractic as deemed necessary to my child.

Signed ______________________________ Date ______________

HEALTH INFORMATION:

Have you had previous chiropractic care? ____________

What is your major complaint? ____________

Other complaints ____________

How long have you had this condition? ____________ Have you had this or similar conditions in the past? ____________

What activities aggravate your condition? ____________

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other ____________

PAST	PRESENT	
☐	☐	Headaches
☐	☐	Neck pain
☐	☐	Neck Stiff
☐	☐	Pins & needles in arms
☐	☐	Numbness in fingers
☐	☐	Head seems too heavy
☐	☐	Mid back pain
☐	☐	Mid back stiffness
☐	☐	Chest pains
☐	☐	Pain around shoulder blade
☐	☐	Shortness of breath
☐	☐	Low back pain
☐	☐	Low back stiffness
☐	☐	Legs ache
☐	☐	Pain in hip
☐	☐	Buttocks sore
☐	☐	Pins & needles in legs
☐	☐	Numbness in toes
☐	☐	Leg cramps
☐	☐	Loss of memory
☐	☐	Lights bother eyes
☐	☐	Nervousness
☐	☐	Insomnia
☐	☐	Dizziness
☐	☐	Depression
☐	☐	Sinus trouble
☐	☐	Ear disorders
☐	☐	Hay fever
☐	☐	Recurrent sore throats
☐	☐	Asthma
☐	☐	Chronic cough
☐	☐	Stomach tension
☐	☐	Indigestion
☐	☐	Nausea
☐	☐	Allergies
☐	☐	Vomiting
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Abdominal pain
☐	☐	Piles/Hemorrhoids
☐	☐	Urinary disorders
☐	☐	Bed wetting
☐	☐	Menstrual disorders
☐	☐	Frigidity
☐	☐	Loss of potency
☐	☐	Other sexual disorders
☐	☐	Tension chronic
☐	☐	Irritability chronic
☐	☐	Fatigue chronic

How long has it been since you really felt good? ____________

Other doctors who have treated this condition ____________

____

List surgical operations and years ____________

____

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ "Pep" Pills

☐ Muscle Relaxers ☐ Tranquilizers ☐ Birth Control Pills

☐ Insulin Others ____________

Age of mattress ____________ ☐ Comfortable ☐ Uncomfortable

Have you been in an auto accident?

☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe ____________

____

Have you had any other personal injury or accident:

☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe ____________

____

Date of Last Physical Examination ____________

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW