Cobb Chiropractic Clinic, PA Dr. Shane A. Cobb, DC

Patient Name: _____

Birthdate: _____ Sex: M F Record Number: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Home Number: (_____) _____ Cell Number: (_____) _____

Email Address: _____

Patient/Guardian SSN: _____

Occupation: _____

Employer: _____

_____

Employer Number: (_____) _____

Work Status: (circle one) Full Time Part Time Student Other

Do we have permission to call your work if necessary? YES NO

Marital Status: (circle one) Married Single Other

Are you a returning patient? YES NO

If not, how did you hear of us? _____

_____

_____

_____

INSURED INFORMATION: Is the patient the- Primary Insurance Holder or a Dependent? (circle one)

Name of the Primary Insurance Holder: (If it is the patient, please say self.) _____

_____

Name of the insurance: _____

Policy Number: _____ Policy effective date: _____

Insurance company phone number: (_____) _____

Birthdate of policy holder: _____ Policy Holder's Employer: _____

Employer's Phone Number: (_____) _____ May we call the employer if necessary? YES NO

Is your visit today accident related? YES NO Were you hurt: ON THE JOB MOTOR VEHICLE ACCIDENT OTHER

If you chose other, please describe: _____

_____

Date of the injury: _____ Have you been to a hospital? YES NO

If yes, did you have: Xrays MRI imaging CT scan (circle all that apply) Did you stay overnight? YES NO

Which hospital were you seen at? _____

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Pain Diagram and Visual Analog Scale

Please read carefully:

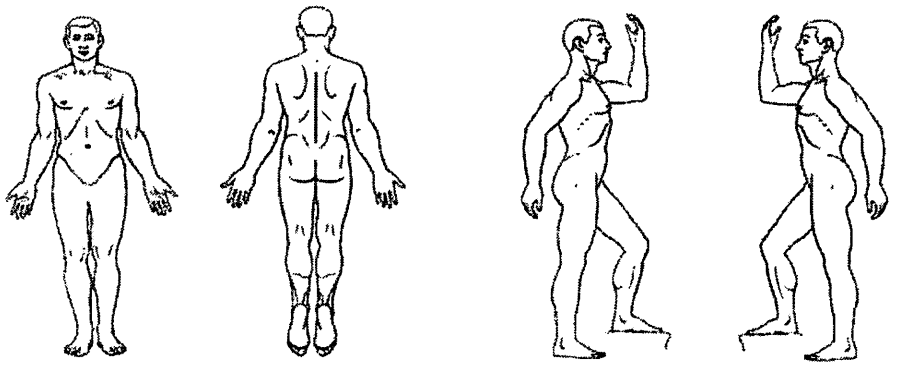
Mark the areas on the diagram below that coincide with your pain. Include all the affected areas. Use as many individual symbols as you'd like to describe the pain intensity.

Indicate radiation of pain by drawing an arrow (→) from the origin of pain to where it stops.

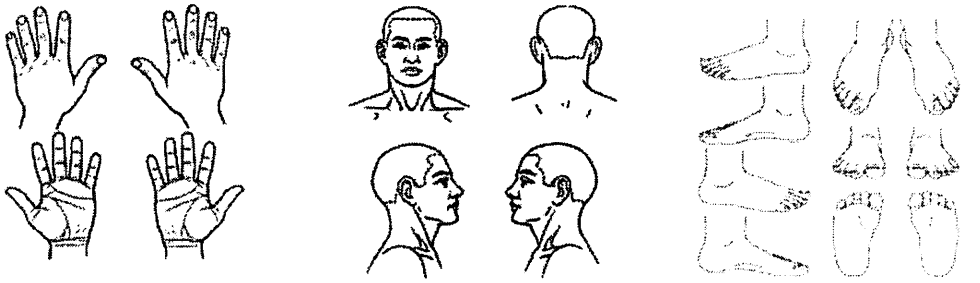
Use the appropriate symbol(s) listed below.

ACHING XXXX XXXX NUMBNESS ==== ==== PINS AND NEEDLES 0000 0000

BURNING >>>> >>>> STABBING //// //// THROBBING + + + + + + + +



HEADACHES



Does anything make the pain better? YES NO

Describe: _____

What makes it worse?

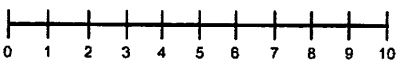
Do you experience: HEADACHES NECK PAIN MID-BACK PAIN LOWER BACK PAIN SHOULDER PAIN (Circle all that apply)

Other: _____

What hurts the worst? _____

How often are your symptoms present? (Intermittent) ----- 0-25% ----- 26-50% ----- 51-75% ----- 76-100% ----- (Constant)

Using the scale to the right, please rate how often your pain has interfered with your daily activities in the past week.



("0" Meaning none, "5" meaning sometimes, "10" meaning constantly)

Has another medical provider seen you for your symptoms? YES NO When? _____

If the answer is "yes", who has treated you? _____

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Check all that apply to you:

_____ Fever within the last week

_____ Diabetes _____ High blood pressure

_____ Epilepsy _____ Siezures _____ Visual disturbances

_____ Corticosteroid use (Cortisone, prednisone, etc.)

_____ Dizziness _____ Fainting

_____ Abnormal weight loss _____ Abnormal weight gain

_____ Cancer/ Tumor Type: _____

_____

_____Stroke Date it occurred: _____

Have you been diagnosed with: (Circle all that apply)

OSTEOARTHRITIS OSTEOPNEA OSTEOPEROSIS

Where? _____

_____

_____ Numbness Where? _____

_____

Do you have a family history of:

_____ Cancer

_____ Heart problems

_____ Stroke

_____ Diabetes

_____ Rheumatoid arthritis

_____ High blood pressure

(Check all that apply)

_____ Other health issues and Surgeries

Explain please: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify to the best of my knowledge the above information is complete and accurate. If the health plan information is not accurate or I am not eligible to receive a health care benefit through this provider, I understand I am liable for all charges for the services rendered. I will notify this doctor and his practice immediately if there is a change in my health condition or a change in my healthcare plan coverage in the future. I understand that a chiropractor or a clinical peer employed by insurance plans may need to contact my physician if my condition needs to be co-managed. This is an authorization that will authorize my chiropractor and/or insurance plans provider permission to contact my physician if necessary.

_____ _____

(Signature) (Date)

Physician's name: _____ Phone number: (_____) _____

Practice name: _____

Address: _____

City: _____ State: _____ Zipcode: _____