PATIENT INFORMATION

Patient Name _____

Date of Birth _____

Cell Phone _____

Home Phone _____

Address _____

City _____ State _____ Zip_____

Email _____

Male Female Age _____

Marital Status _____

Spouse's Name _____

Number of Children _____

Children Names _____

Employer _____

Occupation _____

Primary Care Physician_____

WHO MAY WE THANK FOR REFERRING YOU?

_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my depdent(s), have insurance coverage with

_____
(Name of Insurance Company)

and assign directly to Jacob Seng, D.C. all insurance 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 payments for services and determining insurance benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Representative

_____
Printed Name

_____ _____
Date Relationship to Patient

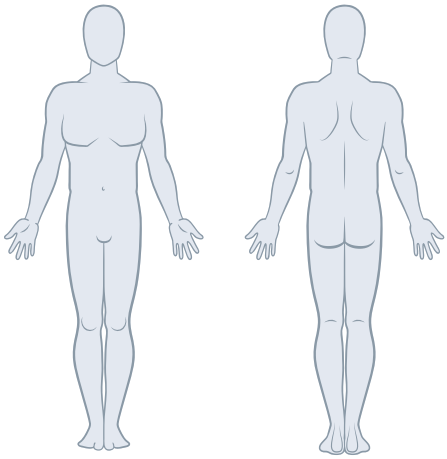
PATIENT CONDITION

☐ Please Check if you are here for wellness care.

Reason for visit _____

When did your symptoms start? _____

Place an "X" on the picture where you have pain numbness or tingling.



Rate the severity of your condition: 0 (least) to 10 (worst) _____

Frequency of Pain: Constant or Intermintant

Does it interfere with: Work Sleep Daily Routine Recreation

Activities that are most painful _____

Is this condition due to an accident? Yes No

Type of Accident: Auto Home Work Other

NORTH STAR CHIROPRACTIC

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Caffeine	Drinks/Day _____
☐ Heavy	☐ Heavy Labor		

What is your stress level? _____

Are you pregnant? YES NO Due Date _____

Have you ever been diagnosed with any diseases, conditions, or syndromes?

_____

INJURIES/SURGERIES YOU HAVE HAD:

Falls _____ Date _____

Head Injuries _____ Date _____

Broken Bones _____ Date _____

Dislocations _____ Date _____

Surgeries _____ Date _____

Medications _____

Allergies _____

Vitamins/Supplements _____

CONSENT FOR TREATMENT

I hearby authorize the doctor, and or his staff to examine me, and perform any necessary diagnostic procedures, including X-ray to fully evaluate my condition for the presence of vertebral subluxation.

Patient or Guardian Signature _____

Printed Name _____ Date _____