WELCOME TO EAST VALLEY FAMILY HEALTHCARE, PC, INC

To ensure proper case information, please provide us with the following information.
If you need assistance in completing these forms, please ask the front desk.

Today's date _____

Name: _____ Nick name preferred: _____

Date of Birth: ____/____/_____ Age: _____ ___ Female ___ Male Soc Sec #: _____-_____-_____

Marital Status ____Single ____Married ____Divorced ____Widowed

Mailing Address						Home Phone		
City, State, Zip						Cell Phone		
Employer						Email		
Employer Address						Work Phone		
City, State, Zip								
Emergency Contact						Phone		

Referred by: ____ Yourself ____ Friend ____ Family Member ____ Insurance Carrier ____ Physician

Name of person who referred you: _____

Primary Care Physician: _____ Are you currently under treatment?_____

INSURANCE (please give insurance card to front desk)

Insurance Company				Insurance Phone #				
Insurance ID#				Insurance Group #				
Policy Holder				Relation to Patient		Birthdate of Policy Holder		

Is the patient covered by additional insurance? ____ Yes* ____ No

If yes: Insurance Company _____ Phone Number _____ Policy ID# _____

Do you have a HRA? YES / NO **Do you have a HSA? YES / NO**

ACCIDENT INFORMATION

Is your condition due to an accident? _____ Yes _____ No **(If yes, please fill out below.)**

Date of Accident _____ Type of Accident _____ Auto _____ Work _____ Other

Has your accident been reported to: _____Your Auto Insurance _____ Employer _____Work Comp _____ Third Party Insurance

Attorney Name (if applicable) _____ Phone _____

PATIENT CONDITION

REASON FOR VISIT _____

_____

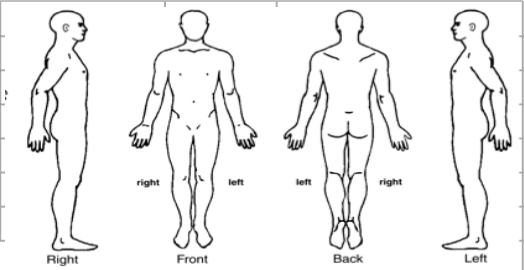
_____

When did your symptoms appear? _____

This condition is getting: ____better ____worse ____no change

How does it feel? ___Aching ___Burning ___Dull ___Sharp ___Stiff

___Throbbing ___Shooting ___Tingling ___Other



Please mark an X on the picture where there is pain, numbness, or tingling.

Circle the severity of your pain on a scale of 0 to 10: **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)**

How often do you have this pain? _____ Is the pain: ___Constant ___Comes and goes

What relieves the pain? ___Ice ___Heat ___Chiropractic ___Massage ___Medication ___Movement ___Resting ___Walking

What makes the pain worse? ___Nothing ___Resting ___Sleeping ___Walking ___Working ___Movement ___Driving

___ Stress ___Computer ___Coughing ___Exercise ___Travel ___Getting up ___Sitting _____Other

What other treatments have you had for this condition? (mark all that apply)

___Chiropractic ____Orthopedic ____Neurologist ____Physical Therapy ____Medication ____Surgery ____ NONE

Name of doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

DAILY LIVING INFORMATION

I now:	**exercise**	yes / no	if yes: ____ per week	**drink caffine**	yes / no	if yes: ____ per week	
	smoke	yes / no	if yes: ____ per week	**drink alcohol**	yes / no	if yes: ____ per week	

I am currently, or have in the past, been:	addicted to drugs (yes / no)	or alcohol (yes / no)	
I have been treated for:	drug addiction (yes / no)	alcohol addiction (yes / no)	

I am now:	_____ working full time	_____ working part-time	_____ homemaker	_____ student	
	_____ unemployed	_____ retired	_____ on disability (full / temporary)	last day worked: _____	

HEALTH HISTORY

Please advise us of any special circumstances, previous tests, therapies or conditions.

Are you allergic to any medications? NO YES

If yes, please list all that you are allergic to below.

Date of Last: _____ Physical Exam _____ X-Ray _____ MRI _____ CT Scan

List any **Medications** you are taking (prescription and over the counter):

Have you had any:	Automobile Accidents	Yes / No	If Yes, Date
	Surgeries	Yes / No	If Yes, Date
	Head Injuries	Yes / No	If Yes, Date
	Broken Bones	Yes / No	If Yes, Date

FEMALES ONLY: Are you now, or could you be pregnant? Yes No First day of last menstrual cycle:

Check each condition with "C" for Current, "P" for Past, or "N/A" for Not Applicable.

____ AIDS / HIV	____Digestion Problems	____High Blood Pressure	____Shortness of Breath
____ Anxiety / Depression	____Earache	____Insomnia	____Stroke
____Arthritis	____Epilepsy	____Kidney Problems	____TMJ
____Asthma	____Headaches	____Osteoporosis	____Ulcers
____Cancer	____Headaches (Migrane)	____Prostate Problems	____Vertigo / Dizziness
____Chronic Fatigue	____Heart Disease	____Rheumatoid Arthritis	____Other _____
____Diabetes	____Herniated Disk	____Sciatica	

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of medical procedures and/or chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, muscle therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed chiropractor and massage therapists who now or in the future treat me while employed by, working at, associated with, or serving as back-up for the chiropractor and/or massage therapists working at East Valley Family Healthcare, PC, Inc. or any other affiliated office and/or clinic.

I have had an opportunity to discuss with the doctor of chiropractic treating me at East Valley Family Healthcare, PC, Inc. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I certify that the above information is correct. I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

TO BE COMPLETED BY PATIENT

Patient Name _____ Signature of Patient _____

PLEASE PRINT

Date Signed _____ Witness of Signature _____

TO BE COMPLETED BY PATIENT OR BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name _____ Signature of Patient and/or Representative _____

PLEASE PRINT

Date Signed _____ Signature of Witness _____

Translated By (if applicable) _____ Date _____