Welcome

Patient Information

Date ______________________________________

SSN ______________________________________

Name ______________________________________
Last

____
First Middle Initial

Address ______________________________________

City ______________________________________

State ____________________ Zip ____________

E-mail ______________________________________

Sex ☐ M ☐ F Age ____________

Birth date ______________________________

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Minor

☐ Partnered for ____ years

Occupation ______________________________

Patient Employer/School _________________

Employer/School Address ________________

____

Spouse's Name _________________________

SSN ______________________________________

Spouse's Employer ______________________

Whom may we thank for referring you?

____

Phone Numbers

Home (_____) __________________________

Cell (_____) __________________________

Best time and place to reach you ___________

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Relationship ____________________________

Home (_____) _________________________

Cell/Work (______)______________________

Accident Information

Is this condition due to an accident? ☐ Yes ☐ No

Date of accident ___________________________

Type of accident ☐Auto ☐Work ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐ Employer ☐ Worker Comp. ☐Other

Attorney Name (if applicable)_________________

Insurance Information

Who is responsible for this account? ________________

Relationship to patient ____________________________

Insurance Co. ______________________________

ID # ___________________ Group # _______________

Subscriber's Name _____________________________

Birth date ________________ SSN ________________

Relationship to patient ___________________________

Is patient covered by additional insurance? Yes No

Insurance Co. ______________________________

ID # ___________________ Group # ______________

Assignment and Release

I certify that I, and/or my dependant(s), have insurance coverage with _________________________ and assign directly to **Dr. Jamie L. Higley** 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 payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Print name of Patient, Parent, Guardian or Personal Representative

______________________ ______________________
Date Relationship to Patient

Treatment Information

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐Other _______

Name and Address of other doctor (s) who have treated you for your condition: __________________________

____

Date of Last:

Physical Exam _____________ Blood Test __________

Spinal X-Ray _____________ Spinal Exam __________

Chest X-Ray _____________ Urine Test ____________

Dental X-Ray ____________

MRI,CT-Scan, Bone Scan ____________

Exercise (circle one)

None
Moderate
Daily
Heavy

Work Activity (circle one)

Sitting
Standing
Light Labor
Heavy Labor

Habits (circle all that apply)

Smoking Packs/Day ______________________

Alcohol Drinks/Week ____________________

Coffee/Caffeine Cups/Day ____________________

High Stress Level Reason _____________________

Are you pregnant? ☐ No ☐ Yes

Due Date ____________________________

Patient Condition

Reason for visit ____

When did your symptoms appear? ____

Is this condition getting progressively worse? ☐Yes ☐ No ☐Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ___________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐Tingling ☐ Cramps ☐ Stiffness ☐ Swelling

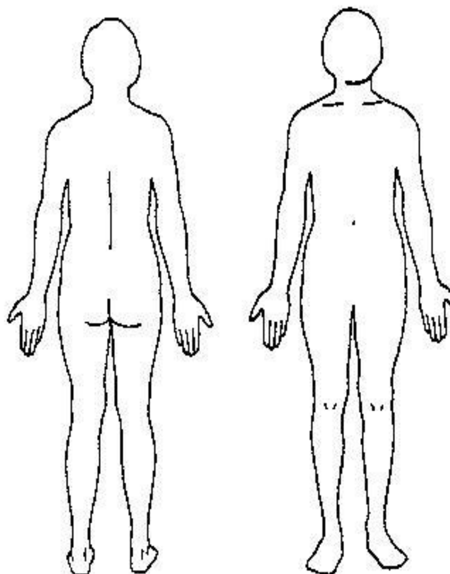
How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with your ☐ work ☐ sleep ☐ daily routine ☐ recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐Walking ☐ Bending ☐ Lying Down

Mark an **X** on the picture where you continue to have pain, numbness, or tingling.



Health History

Injuries/Surgeries you have had

	Description	Date
Falls	________________________________	__________
Head Injuries	________________________________	__________
Broken Bones	________________________________	__________
Dislocations	________________________________	__________
Surgeries	________________________________	__________

Medications: ____

Circle all that apply.

- AIDS/HIV
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Chemical Dependency
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herniated Disk
- Herpes
- High Cholesterol
- Kidney Disease
- Liver Disease
- Lyme's Disease
- Measles
- Migraine Headaches
- Miscarriage
- Multiple Sclerosis
- Mumps
- Osteoporosis
- Pacemaker
- Parkinson's Disease
- Pinched Nerve
- Pneumonia
- Polio
- Prostate Problem
- Psychiatric Care
- Rheumatoid Arthritis
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Tumors, Growths
- Ulcers
- Venereal Disease
- Whooping Cough
- Other __________