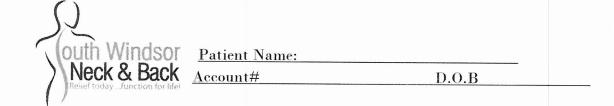




	PATIENT INFORMATION						
Patient Name:							
	Marital Status: Single □ Married	□ Divorced □ Widowed □					
	City:						
	Cell:						
	Email address:						
Date of Birth:	Age:	Sex: Male □ Female □					
Employer/ School:	Position/ Grade:						
	Telephone:						
Primary Care Physician:	Telephone:						
	PERSON RESPONSIBLE FOR PAYMENT						
Responsible Party:	Telephone:						
Self □ Mother □ Fath	ner □ Step Parent □ Spouse □ Other	(Specify)					
Address:	Zip Code:						
Date of Birth:	Social Security #	<i>‡</i> :					
understand that my insurance companing care. If my insurance company requinderstand I am responsible financially records to my other doctors and to my lacknowledge that I have access to and to	AT THE TIME OF SERVICE UNLESS PRIOR ARRANGED by may require a referral for care. If I do not have a valid referratives referrals and I fail to obtain a referral, I agree to assume relif my insurance is not covering my visits. I hereby give South Whealth insurance company, including psychiatric, substance abuunderstand the HIPAA privacy agreement; I understand that I mittled to receive a written copy of these policies at my request cy is amended or changed.	al, my insurance company could refuse to pay for sponsibility for payment of my charges. I indsor Neck & Back, LLC permission to release my se and AIDS related information. Further, I ay contact the office manager if I have further					
Signature:	Da	te:					



CHIEF COMPLAINT(S):						
Date of onset:						
How did it happen? Were you working at the time? □ Yes □ No						
What makes it feel better?						
What makes it feel worse?						
How does it feel? (sharp, shooting, stiff, dull, aching etc.)						
What time of day is it best? Worst? \(\square\) No timing						
How severe is it? (1-10) with 0 being no pain and 10 being unbearable pain?						
What other providers have you seen for this condition? □ MD □ DC □ PT □ Other:						
Are you still seeing them? □ Yes □ No						
Do you have a permanent disability rating? No Yes% Location: What activities have been affected by this condition?						
When was the last time you felt really good?						
What are your goals with care?						
If we were your "Health Genies", what would be your ONE wish?						

General		Orthopedic	Habits	
Not Applicab		Not Applicable	Not Applical	ble
Anxiety/Depre		TMJ	Alcohol	ACOUNTED THE SECURICAL SECURICA SECURICA SECURICA SECURICA SECURICA SECURICA SECURICA SECURICA SECURICA SE
Change in app		Neck pain	Balanced die	t
Difficulty slee		Mid back pain	Coffee	
Excessive blee		Low back pain	Regular exerc	cise
Excessive thir	st	Shoulder pain	Stress	
Fatigue		Elbow pain	Tobacco	
Fever		Wrist pain	Family H	listory
Heat/cold into		Hand pain	Not Applical	The second secon
Loss of appeti		Pelvic/SI pain	Arthritis	
Nausea/vomit	ing	Hip pain	Bladder/kidne	ev disease
Night sweats		Knee pain	Cancer	oj arsease
Sudden weigh		Ankle pain	Diabetes	The same of the sa
Swollen gland	S	Foot pain	Heart disease	
Illnesses		Eyes/Ears	High blood pi	
Not Applicab	le	Not Applicable	Neurological/	
AIDS		Blurred vision	Thyroid disea	
Asthma		Double vision	Allergie	
Arthritis		Eye pain	Ancigie	29 (1121)
Cancer	The state of the s	Ear pain		
Diabetes	The state of the s	Loss of hearing		Market and a service service services
Fibromyalgia		Ringing in the ears		
Glaucoma	Manufacture and a manufacture and a supplied of the supplied o	Nose/Throat	Surgeries (list	w/ dates
Heart disease	The second control of	Not Applicable		
Hepatitis	The state of the s	Chronic discharge		
Hypertension		Hoarseness		
High cholester	ol	Nosebleeds		andro
Immune disord	ler	Sinus problems		
Kidney stones		Trouble swallowing		
Osteoporosis	The state of the s	Abdomen		
Prostate diseas	e r			
Shingles		Not Applicable Change in stool	Medicatio	ns (list)
Skin condition		Constipation		
Stroke		Diarrhea		
Tuberculosis		Food allergy		
Thyroid diseas	e	Heartburn		A TOPATONA MARINA M
Ulcer		Pain		
Neurologi	ical	Urine		MATERIAL CONTRIBUTION CONTRIBUTION SHOWS SHOW
Not Applicabl	e r			
Dizziness	-	Not Applicable Awaken to urinate		
Fainting	and the second s	Burning sensation		
Headaches		Excessive urination		
Head trauma		Incontinence	The Training and Training	/3 *
Numbness/ting	ling	Urinary retention	Vitamins	(list)
Seizures				
Weakness		Woman		
Chest		Not Applicable		
Not Applicable	e l	Breast masses		
Cough		Endometriosis		TANKAR MARINAN MENENGAN
Heart palpitation	ons	Irregular menstruation		
		Perimenopausal PMS		
Chest pain	1 1			

Consent Form

PATIENT CONSENT: By answering the following questions, you will assist our team in identifying if you are a qualified to receive the application of today's treatment.

Are you pregnant?		Yes	No
Do you have cancer/tumor?		Yes	No 🗌
Do you have a skin infection?		Yes	No 🗌
Are 16-years of age or younger?		Yes	No 🗌
Do you have a tear in the tendon?		Yes	No 🗌
Do you have a cardiac pacemaker?		Yes	No 🗌
Do you have bleeding disorder/tendency to bleed?		Yes	No 🗌
Are you on NSAIDS, OPIOIDS or anti-coagulant treatment?		Yes	No 🗌
Have you received a cortisone injection within the last 30-days?		Yes	No 🗌
RISKS OF PROCEDURE: There may be temporary pain &/or soreness.	eated.		
I,	for the absearched ysician/store a discussion of the second properties	pove stated I the treatm aff. I confirmussion to cl t been pron	I issues. I nent option m that larify any mised to
Signature:	Date	:	