Schwan Chiropractic & Acupuncture **PATIENT INFORMATION**

Last Name: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

Birthdate: ___/___/___ Age: ___ Sex: M ☐ ☐ Marital Status: ☐ Single ☐ Married ☐ Seperated

Responsible Party: Guardian/Parent_____ ☐ Divorced ☐ Widowed

Relationship to Patient: _____

Emergency Contact: _____ Phone: _____

Primary Insured Information:

Primary Insurance: _____ Employer: _____

Policy #:_____ Group #:_____

Last Name: _____ First:_____Middle:_____

Address: (if different from patient):_____

City: _____ State:_____ Zip:_____

Birthdate: _____/_____/_____ Age: _____ Sex: M ☐ ☐ Soc. Sec. #_____

Relationship to Patient: _____

Secondary Insured Information:

Secondary Insurance: _____ Employer: _____

Policy #:_____ Group #:_____

Last Name: _____ First:_____Middle:_____

Address: (if different from patient):_____

City: _____ State: _____ Zip: _____

Birthdate: _____/_____/_____ Age: _____ Sex: M ☐ ☐ Soc. Sec. #_____

Relationship to Patient:_____

1. I acknowledge that the above information is true to the best of my knowledge. 2. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred. 3. I hereby authorize the direct payment to Douglas Schwan, D.C., Schwan Chiropractic & Acupuncture Center, of any sum I now or hereafter owe you by my attorney out of any proceeds of any settlement of my case, and/or by any insurance company obligated to make payment based in whole or in part upon the charges are made for your services. 4. I understand that I am financially responsible for any balances not covered. 5. I hereby authorize the use of this signature on all my insurance submissions.

Authorized Signature: _____ Date: _____

Additional History:

Occupation:_____

Primary Care Physician (PCP):_____Phone:_____

Date of Last Physical Exam:_____ Referred by:_____

Please describe your current problem: _____

_____

Is your current problem result of: Auto Accident? Y ☐N☐ Work Accident? Y☐ N☐ Slip & Fall? Y☐ N☐

How did your problem begin: _____

_____

Date Problem Began: _____ Other Doctors seen for this condition: _____

List other treatments or tests you have had for this condition:_____

_____

Have you been treated for any other health condition by a physician in the last year? ☐Yes ☐ No

If yes, Explain_____

_____

How often are you symptoms present? ☐Constantly ☐Frequently ☐Occasionally ☐Intermittently

Describe your current pain/symptoms: ☐Sharp/Stabbing ☐ Burning ☐ Throbbing ☐ Shooting

☐ Tingling☐ Gripping ☐ Dull☐ Numbness☐ Soreness☐ Aches ☐ Weakness☐ Other_____

Since it began, is your problem: ☐Improving ☐ Getting Worse ☐No Change

What makes the problem better: ☐Nothing ☐Lying Down ☐Standing ☐ Walking ☐ Sitting

☐ Movement ☐ Exercise ☐Inactivity/Rest Other:_____

What make the problem worse: ☐Nothing ☐Lying Down ☐ Standing ☐Walking☐ Sitting

☐ Movement ☐ Exercise ☐Inactivity/Rest ☐Other:_____

Can you perform daily home activities? ☐ Yes ☐ With Help ☐ No

Do you exercise? ☐ Yes, Almost daily ☐ Yes, Occasionally ☐ Not at all

Describe your job requirements: ☐ Mainly Sitting ☐Light Labor ☐ Heavy Labor

Can you perform your daily work activities? ☐Yes ☐ With Help ☐ No

Describe your stress level: ☐ None to Mild ☐Moderate ☐ High