ANN O. MICHAEL. DC, CC

Welcome

Date: ___/___/___ Patient Name: _____
Last First MI

What you prefer to be called: _____ Date of Birth: ___/___/___ Age: ___ ☐ Male ☐ Female

Social Security Number: _____ Driver's License Number: _____

Email _____

Home Number: _____ Work Number: _____ Cell/Other Number: _____

Phone number we can leave messages at: _____

Is it okay to leave a message with the person answering the telephone? Yes_____ No_____

Home Address: _____
City State Zip

Mailing Address: _____
City State Zip

Employer's Name: _____ How Long?: _____

Occupation: _____ Referred by: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Spouse/Partner's Name: _____ Do you have children? ☐ Yes ☐ No How many? _____

Emergency Contact

Who should we contact? _____ Relationship: _____

Home Phone Number: _____ Work Number: _____ Other Phone Number: _____

Who is your medical doctor? _____ Phone Number: _____

Health Insurance

WE ARE NOT ABLE TO BILL YOUR NSURANCE COMPANY FOR YOU. WE DO SUPPLY A SUPER BILL WITH ALL THE NECESSARY CODES FOR YOU TO SUBMIT.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

WE ACCEPT CASH, CREDIT CARDS AND CHECK.

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Date: ___/___/___ Patient Name: _____

Auto Insurance (if you are being treated for injuries sustained in a MVC)

Date of Accident: ____/____/____

Who is responsible for this account? _____ Relationship to Patient: _____

Insurance Company: _____

Address: _____

City State Zip

Adjuster/Contact Person: _____ Phone Number: _____

Claim #: _____

Attorney's Name: _____ Phone Number: _____

Address: _____

City State Zip

Insured's Name: _____ Insured's Date of Birth: ___/___/___

Insured's Employer: _____

I, the undersigned certify that I UNDERSTAND THAT DR ANN MICHAEL WILL NOT BE BILLING THE INSURANCE COMPANY'S DIRECTLY AND THAT I will be submitting the Personal injury claims for her services.

She will provide me with the necessary forms and chart notes as per request from the insurance company

_____

Signature Date

■ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

■ Our policy requires payment in full for all services rendered at the time of visit.

■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

■ I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ___/___/___

☐ Adult Patient ☐ Parent or Guardian

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Date: ___/___/___ Patient Name: _____

Reason for Visit

What is your symptoms(s): _____

_____

When did your symptom(s) appear? _____

Was it sudden or gradual? _____

How did it happen? _____

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

Rate the severity of your pain on a scale from 0 (least pain) to 10 (severe pain): _____

What percentage of the time you are awake do you experience the above symptom(s) at the above intensity?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

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

☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Is it constant or does it come and go? _____

Does it radiate to another part of your body? No Yes, where_____

Is the symptom(s) worse at certain times of the day or night? (circle one):

Morning Afternoon Evening Night Unaffected by time of day

What makes the symptom(s) better? _____

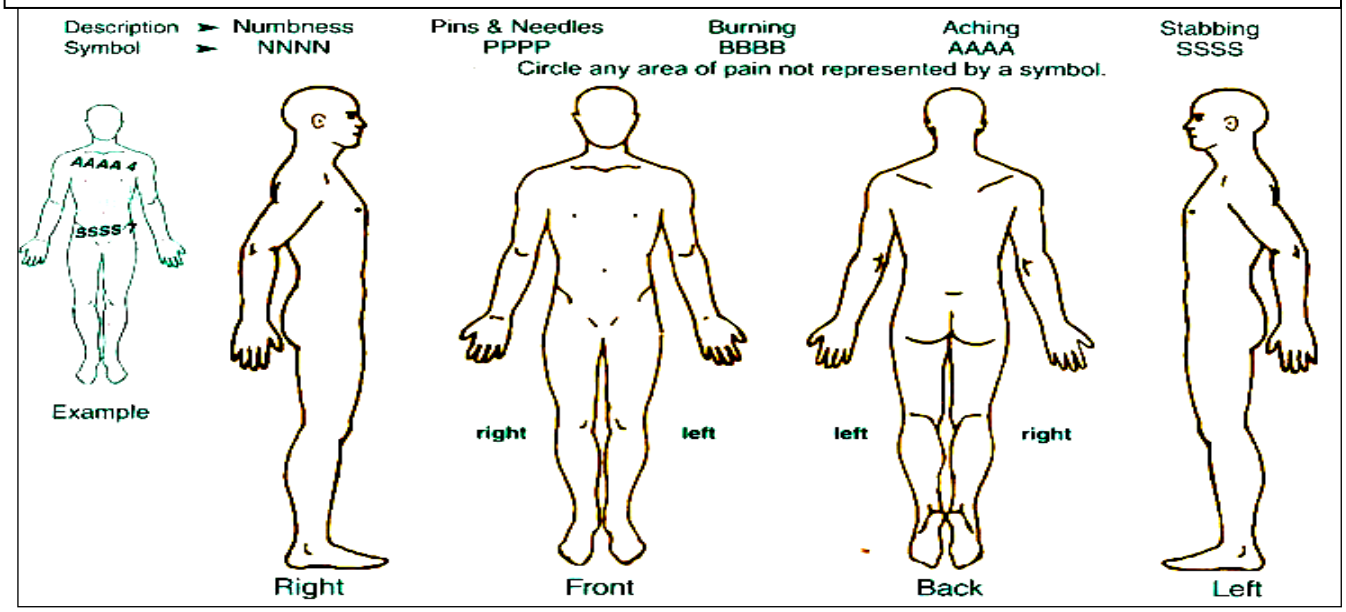
What makes the symptom(s) worse? _____

What treatment have you already received for your condition? (please circle): Physical Therapy Chiropractic

Acupuncture Surgery None Other _____

Name of provider(s) that has treated you for this condition: _____

Telephone number of provider(s) that has treated you for this condition: _____



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Date: ___/___/___ Patient Name: _____

Review of Symtoms

What is your current weight: _____lbs., and Height _____Ft. _____In.

Please mark "Current" "Past" or "N/A" to indicate if you have had (current or past) any of the following:

AIDS/HIV	☐ Current	☐ Past ☐ N/A	Liver Disease	☐ Current	☐ Past ☐ N/A
Alcoholism	☐ Current	☐ Past ☐ N/A	Measles	☐ Current	☐ Past ☐ N/A
Allergy Shots	☐ Current	☐ Past ☐ N/A	Migraine Headaches	☐ Current	☐ Past ☐ N/A
Anemia	☐ Current	☐ Past ☐ N/A	Miscarriage	☐ Current	☐ Past ☐ N/A
Anorexia	☐ Current	☐ Past ☐ N/A	Mononucleosis	☐ Current	☐ Past ☐ N/A
Appendicitis	☐ Current	☐ Past ☐ N/A	Multiple Sclerosis	☐ Current	☐ Past ☐ N/A
Arthritis	☐ Current	☐ Past ☐ N/A	Mumps	☐ Current	☐ Past ☐ N/A
Asthma	☐ Current	☐ Past ☐ N/A	Osteoporosis	☐ Current	☐ Past ☐ N/A
Bleeding Disorders	☐ Current	☐ Past ☐ N/A	Pacemaker	☐ Current	☐ Past ☐ N/A
Breast Lump	☐ Current	☐ Past ☐ N/A	Parkinson's Disease	☐ Current	☐ Past ☐ N/A
Bronchitis	☐ Current	☐ Past ☐ N/A	Pinched Nerve	☐ Current	☐ Past ☐ N/A
Bulimia	☐ Current	☐ Past ☐ N/A	Pneumonia	☐ Current	☐ Past ☐ N/A
Cancer	☐ Current	☐ Past ☐ N/A	Polio	☐ Current	☐ Past ☐ N/A
Cataracts	☐ Current	☐ Past ☐ N/A	Prostate Problem	☐ Current	☐ Past ☐ N/A
Chemical Dependency	☐ Current	☐ Past ☐ N/A	Prosthesis	☐ Current	☐ Past ☐ N/A
Chicken Pox	☐ Current	☐ Past ☐ N/A	Psychiatric Care	☐ Current	☐ Past ☐ N/A
Diabetes	☐ Current	☐ Past ☐ N/A	Rheumatoid Arthritis	☐ Current	☐ Past ☐ N/A
Emphysema	☐ Current	☐ Past ☐ N/A	Rheumatic Fever	☐ Current	☐ Past ☐ N/A
Epilepsy	☐ Current	☐ Past ☐ N/A	Scarlet Fever	☐ Current	☐ Past ☐ N/A
Fractures	☐ Current	☐ Past ☐ N/A	Stroke	☐ Current	☐ Past ☐ N/A
Glaucoma	☐ Current	☐ Past ☐ N/A	Suicide Attempt	☐ Current	☐ Past ☐ N/A
Goiter	☐ Current	☐ Past ☐ N/A	Thyroid Problems	☐ Current	☐ Past ☐ N/A
Gonorrhea	☐ Current	☐ Past ☐ N/A	Tonsillitis	☐ Current	☐ Past ☐ N/A
Gout	☐ Current	☐ Past ☐ N/A	Tuberculosis	☐ Current	☐ Past ☐ N/A
Heart Disease	☐ Current	☐ Past ☐ N/A	Tumors, Growths	☐ Current	☐ Past ☐ N/A
Hepatitis	☐ Current	☐ Past ☐ N/A	Typhoid Fever	☐ Current	☐ Past ☐ N/A
Hernia	☐ Current	☐ Past ☐ N/A	Ulcers	☐ Current	☐ Past ☐ N/A
Herniated Disk	☐ Current	☐ Past ☐ N/A	Vaginal Infections	☐ Current	☐ Past ☐ N/A
Herpes	☐ Current	☐ Past ☐ N/A	Venereal Disease	☐ Current	☐ Past ☐ N/A
High Cholesterol	☐ Current	☐ Past ☐ N/A	Whooping Cough	☐ Current	☐ Past ☐ N/A
Kidney Disease	☐ Current	☐ Past ☐ N/A	Other _____		

For Women: Are you pregnant? ☐ Yes ☐ No Due Date: ____/____/____
Date of Last Menstrual Period: _____/_____/____

Injuries/Surgeries you have had: Description Date

Falls_____
Head Injuries_____
Broken Bones_____
Dislocations_____
Surgeries_____
_____

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Date: ___/___/___ Patient Name: _____

M E D I C A T I O N S

_____ _____
_____ _____
_____ _____
_____ _____

For women: Are you taking Birth Control? ☐Yes ☐N o

SUPPLEMENTS and VITAMINS

_____
_____
_____
_____

A L L E R G I E S

_____
_____
_____
_____

Family Health History

Any family history of the following? Check all that apply and state who has/had the condition.

- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ High Blood Pressure_____
- ☐ Cardiovascular Problems_____
- ☐ Stroke/TIA_____

D A I L Y H A B I T S

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Daily _____
☐ High Stress Level Reason _____

Sleep ___ hrs/night Sleep well? Y N Wake Rested? Y N Do you take medication for sleep? Y N
What age is your mattress? _____ Is it comfortable? ☐ Yes ☐ No
In what position do you sleep? _____
How many pillows do you use? _____

Do you exercise regularly? Yes No
Type _____
Frequency _____