



1607 NE Alberta
Portland, OR 97211

PATIENT INFORMATION

Date: _____

Patient: _____

Address: _____

Sex: M F Age: _____ Birthdate: _____

Single Married Widowed Separated Divorced

Patient SS #: _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____ SS #: _____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home: _____ Work: _____ Ext: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

PATIENT CONDITION

Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

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

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

Type of pain: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with work Sleep Daily Routine Recreation Other

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

INSURANCE

Who is responsible for this account? _____

Relationship to patient: _____

Insurance co: _____

ID #: _____

Is patient covered by additional insurance? Yes No

Subscriber's name: _____

Birthdate: _____ SSN: _____

Relationship to Patient: _____

Insurance Co: _____

Group #: _____

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Joseph Medlin, DC 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

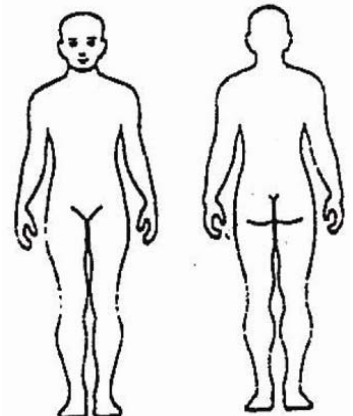
Date: _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto insurance Employer Worker Comp Other

Attorney Name (if applicable): _____



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery PT
 Chiropractic Services None Other _____

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

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shot <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple _____	Suicide attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problem <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor growth <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated disc <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chemical dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE

None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

Sitting
 Standing
 Light labor
 Heavy labor

HABITS

Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High stress level Reason _____

Are you pregnant? Yes No Due Date: _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

 Pharmacy name : _____
 Pharmacy number: _____