



1607 NE Alberta
Portland, OR 97211
503-788-6800

PATIENT INFORMATION

Date: _____
Patient: _____
Address: _____

Email: _____
Sex: M F Age: _____ Birthdate: _____
 Single Married Widowed Separated Divorced
Patient SS #: _____
Occupation: _____
Employer: _____
Employer Phone: _____
Spouse's Name: _____ Birthdate: _____
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 Turning Getting Up

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 #: _____

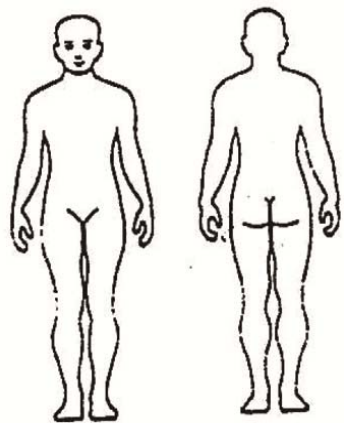
Assignment and Release:

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:

Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Concussion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herniated Disc	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psoriatic Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tumor Growth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Whiplash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

EXERCISE

None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

Sitting
 Standing
 Light labor
 Heavy labor

HABIT

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

DIET

Excellent
 Good
 Mediocre
 Poor

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

