Welcome to Adams Clinic

Patient Information

Date: _____

Patient SS#: _____

Patient Name: _____

(Last Name)

_____

(First Name) (MI)

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: □ M □ Female Age: _____

Birthdate: _____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered for _____ years

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: (_____)_____

Spouse's Name: _____

Birthdate: _____

SS#: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account?_____

Relationship to Patient: _____

Insurance Co.: _____

Member ID#: _____

Group #: _____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name: _____

Birthdate: _____ SS#: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above companies and assign directly to Dr. Jeremy T. Adams 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 authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient or Guardian:_____

Date:_____ Relationship to Patient:_____

Phone Numbers

Home Phone: (_____) _____

Cell Phone: (_____) _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship:_____

Home Phone: (_____) _____

Cell Phone: (_____) _____

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):

_____

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 of 1 (least pain) to 10 (sever pain):_____

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

How often do you have this pain? _____

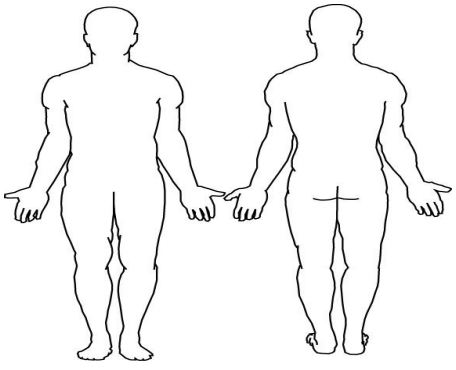
Is it constant or does it come and go? _____

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

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

Height: ____ ft. _____in. Weight: _____lbs.

Dominant/Major Hand: □ Right □ Left



Health History

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy

□ 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	□Yes □No	Epilepsy	□Yes □No	Migraine	□Yes □No	Stroke	□Yes □No
Alcoholism	□Yes □No	Fractures	□Yes □No	Headaches	□Yes □No	Suicide Attempt	□Yes □No
Allergy Shots	□Yes □No	Glaucoma	□Yes □No	Miscarriage	□Yes □No	Thyroid Problems	□Yes □No
Anemia	□Yes □No	Goiter	□Yes □No	Mononucleosis	□Yes □No	Tonsilillitis	□Yes □No
Anorexia	□Yes □No	Gonorrhea	□Yes □No	Mumps	□Yes □No	Tuberculosis	□Yes □No
Appendicitis	□Yes □No	Gout	□Yes □No	Osteoporosis	□Yes □No	Tumors, Growths	□Yes □No
Arthritis	□Yes □No	Heart		Pacemaker	□Yes □No	Typhoid Fever	□Yes □No
Asthma	□Yes □No	Disease	□Yes □No	Parkinson's		Ulcers	□Yes □No
Bleeding		Hepatitis	□Yes □No	Disease	□Yes □No	Vaginal Infections	□Yes □No
Disorders	□Yes □No	Hernia	□Yes □No	Pinched		Venereal Disease	□Yes □No
Breast Lump	□Yes □No	Herniated		Nerve	□Yes □No	Whooping Cough	□Yes □No
Bronchitis	□Yes □No	Disk	□Yes □No	Pneumonia	□Yes □No	Other: _____	
Bulimia	□Yes □No	Herpes	□Yes □No	Polio	□Yes □No	_____	
Cancer	□Yes □No	High		Prostate Problem	□Yes □No		
Cataracts	□Yes □No	Cholesterol	□Yes □No	Prosthesis	□Yes □No		
Chemical		Hypertension	□Yes □No	Psychiatric Care	□Yes □No		
Dependency	□Yes □No	Kidney		Rheumatiod			
Chicken Pox	□Yes □No	Disease	□Yes □No	Arthritis	□Yes □No		
Diabetes	□Yes □No	Liver Disease	□Yes □No	Rheumatic Fever	□Yes □No		
Emphysema	□Yes □No	Measles	□Yes □No	Scarlet Fever	□Yes □No		

Exercise	**Work Activity**	**Habits**	
□ None	□ Sitting	□ Smoking	Packs/Day: _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week:_____
□ Daily	□ Light Labor	□ Coffe/Caffeine	Cups/Day:_____
□ Heavy	□ Heavy Labor	□ 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 Phone: (_____) _____		

Signature: _____ Date: _____