Amosson Chiropractic
Dr. Kelly Jean Amosson
3510 Kimball Ave. Waterloo, IA 50702

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Referred by: _____

Phone #'s: Home _____ Work _____ Ext _____

Cell _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work 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) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my insurance companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize direct payment to my doctor.
I permit a copy of this authorization to be used in place of the original.

With or without the benefits of insurance, patient/guardian is responsible for payment after services are rendered. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges. Iowa check law enforced - $50.00. Minimum $5.00 or 1 1/2% (18 APR), and all legal and collection costs until remitted or paid in full. Please pay promptly to avoid extra costs.

_____
Signature

_____
Relationship Date

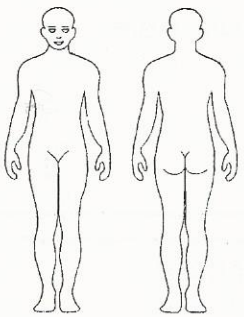
PATIENT CONDITION

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 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

- OVER -

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 _____

Have you had X-rays within the last year? _____

	never	previously	presently	
GENERAL				
1.	☐	☐	☐	anemia
2.	☐	☐	☐	cancer or tumor
3.	☐	☐	☐	diabetes
4.	☐	☐	☐	epilepsy
5.	☐	☐	☐	hepatitis
6.	☐	☐	☐	polio
7.	☐	☐	☐	rheumatic fever
8.	☐	☐	☐	scarlet fever
9.	☐	☐	☐	thyroid conditions
10.	☐	☐	☐	sexually transmitted diseases
11.	☐	☐	☐	surgeries-any type
12.	☐	☐	☐	surgery spinal
13.	☐	☐	☐	AIDS or AIDS related complex
14.	☐	☐	☐	tuberculosis
BY SYSTEMS				
15.	☐	☐	☐	convulsions
16.	☐	☐	☐	dental problems/TMJ
17.	☐	☐	☐	dizziness
18.	☐	☐	☐	mental illness
19.	☐	☐	☐	nervousness, depression
20.	☐	☐	☐	headaches
21.	☐	☐	☐	paralysis
22.	☐	☐	☐	sweats
23.	☐	☐	☐	tremors
24.	☐	☐	☐	weight gain/loss
25.	☐	☐	☐	alcoholism
26.	☐	☐	☐	childhood diseases
EYES, EARS, NOSE, THROAT				
27	☐	☐	☐	chronic colds
28.	☐	☐	☐	chronic cough
29.	☐	☐	☐	chronic sore throat/hoarseness
30.	☐	☐	☐	sinusitis
RESPIRATORY				
31	☐	☐	☐	allergies
32.	☐	☐	☐	pneumonia
33.	☐	☐	☐	difficulty breathing
34.	☐	☐	☐	chest/rib area pain
35.	☐	☐	☐	other
CARDIOVASCULAR				
36.	☐	☐	☐	chest pain
37.	☐	☐	☐	rapid heartbeat
38.	☐	☐	☐	high or low blood pressure
39.	☐	☐	☐	varicose veins
40.	☐	☐	☐	other
MUSCULOSKELETAL				
41.	☐	☐	☐	arthritis
42.	☐	☐	☐	low back pain
43.	☐	☐	☐	neck pain
44.	☐	☐	☐	pain around shoulders
45.	☐	☐	☐	swollen joints
46.	☐	☐	☐	muscle weakness
47.	☐	☐	☐	tingling sensations
GASTROINTESTINAL				
48.	☐	☐	☐	appetite change
49.	☐	☐	☐	excessive gas
50.	☐	☐	☐	constipation/diarrhea
51.	☐	☐	☐	nausea
52.	☐	☐	☐	abnormal stool
53.	☐	☐	☐	colitis
54.	☐	☐	☐	gallbladder problems
55.	☐	☐	☐	liver problems
56.	☐	☐	☐	stomach pain
GENITOURINARY				
57.	☐	☐	☐	excessive urination
58.	☐	☐	☐	blood in urine
59.	☐	☐	☐	painful urination
60.	☐	☐	☐	kidney problems
61.	☐	☐	☐	prostate problems
FEMALE REPRODUCTIVE				
62.	☐	☐	☐	premenstrual syndrome
63.	☐	☐	☐	menstrual problems
64.	☐	☐	☐	menopausal problems
65.	☐	☐	☐	breast soreness/lumps

Medications	Vitamins/Herbs/Minerals
_____	_____
_____	_____
_____	_____

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 _____