Spine & Neuromuscular Associates of S.E.I., P.S.C. #_____

First Name Middle Initial Last Name

Home Address City State Zip Code

E-mail address _____ SS# _____

Date of Birth _____ Age _____ Male or Female _____

Please circle: Single Married Widowed Divorced

Home ph. _____ Work ph. # _____ Cell ph. # _____

Circle Provider of Mobile: Verizon Sprint T-Mobile Nextel AT &T Track Mobile

Medical Doctor Name _____ Phone # _____

Employer _____ Occupation _____

In case of emergency contact _____ Phone # _____

Nearest relative not living with you _____ Home ph. # _____ Cell ph. # _____

Please name the person who referred you here _____

HEALTH INSURANCE INFORMATION

Ins. Co. name _____ Ins. carried under Self, Spouse, Parent or Step Parent?

Name of insured _____ Date of Birth _____

Insured Address _____ City _____ State _____ Zip _____

The employers name that covers the insured _____

ID / Group # on insurance card _____

I authorize the use of this information for insurance billing, the release of information to the insurance company, I am responsible for my charges for services, and authorize payment to Spine & Neuromuscular Assoc. of S.E.I., P.S.C., and permit a copy of this authorization to be used in place of the original. Your insurance policy is between you and your insurance company. We will file your claims as a courtesy to you however; you are ultimately responsible for all bills and may be responsible for out of network charges and deductibles. Co-payments are due at the time of service. "NO SHOWS" WILL BE BILLED if you don't give us 24 hour notice.

MEDICARE DMEPOS SUPPLIER STANDARDS

The products and/or services provided to you by (Spine & Neuromuscular Associates of S.E.I., P.S.C) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulation Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

Signed _____ Date_____/_____/_____

Spine &Neuromuscular Associates of S.E.I., P.S.C.
Confidential Case History for Chiropractic File # _____

First Name Middle Initial Last Name

Please list your Chief Complaints:

- _____
- _____
- _____

Do you feel your symptoms are mild, moderate, or severe? _____
What worsens your symptoms? _____
How long have your symptoms been present? _____
What makes your symptoms better? _____
How did your symptoms start? Suddenly Gradually Long-standing problem
Are your symptoms: Constant Progressive Intermittent
Have you had the *same or similar symptoms* in the past? Y / N
Have you had any prior treatment or testing regarding this problem? _____
_____
Are your symptoms due to a Recent Injury? Y / N Date Of Injury _____

Type Of Injury: Auto Accident Personal Injury Workers Compensation
Please describe your accident_____
Have you had any past injuries we should know about? _____ **Please list the year and type of injury**
_____
Please list *all medications* you are currently taking _____
_____
Please list *all surgeries* you've ever had (including breast implants) _____
_____
Do your symptoms interfere with daily living? Y or N with your sleep? Y or N
Do your symptoms interfere with your lifestyle? Y or N with your work? Y or N
Have you missed any work due to this problem? _____
Have you had any past illnesses you feel are significant? _____
_____
Family history of illness? Example: Dad-diabetic, Mom-high B/P, Sister-scoliosis_____
_____
<u>Please circle the condition that describes your work environment</u>
Loud- Lung Pollutant-Extreme Hot/Cold- Constant Sitting-Constant Standing

Tobacco use: none cigarettes cigars pipe chew dip Quit _____
Do you exercise? None—occasional—regularly—type of exercise_____

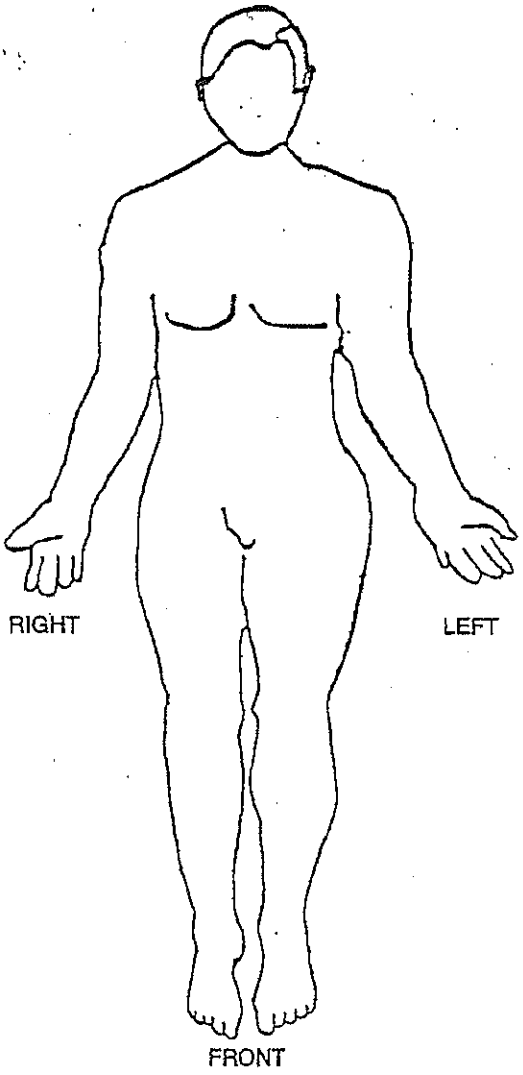
Have you tested positive for HIV/Aids or Hepatitis? No or Yes Have you experienced any recent traumas such as divorce, death of family or friend, job loss, change in residence?
_____
Please circle your race: Asian Black Hispanic White Other_____
Circle the highest level of education completed: High School College Post Graduate
Have you been treated by a chiropractor before? _____ **Dr.**_____
Were your results satisfactory? _____

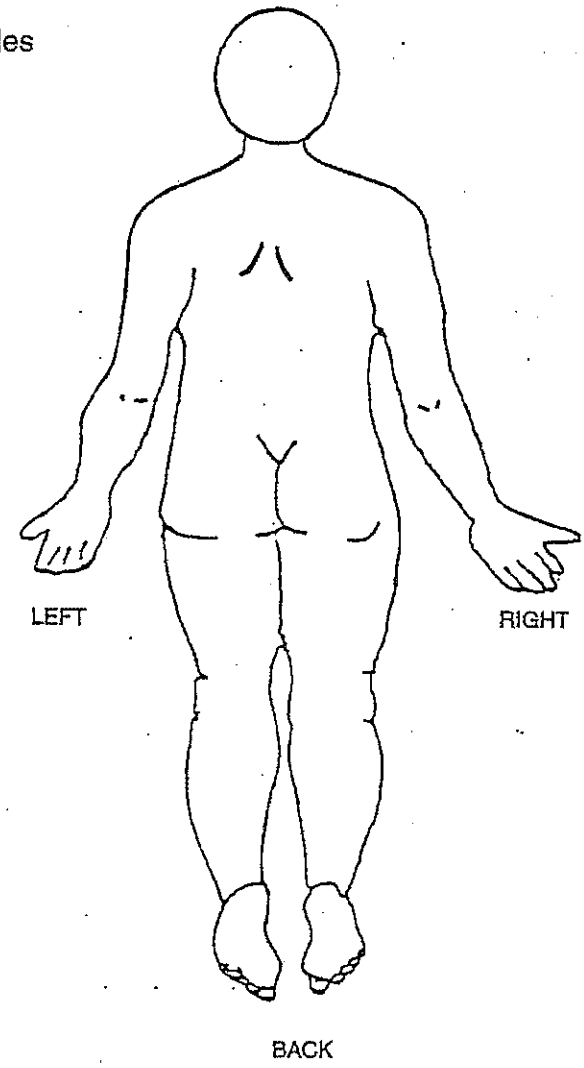
Women Only - Is there any chance you are currently pregnant? _____
I have read the above information and answered to the best of my ability.
Date _____ **Signature** _____

BODY SHEET

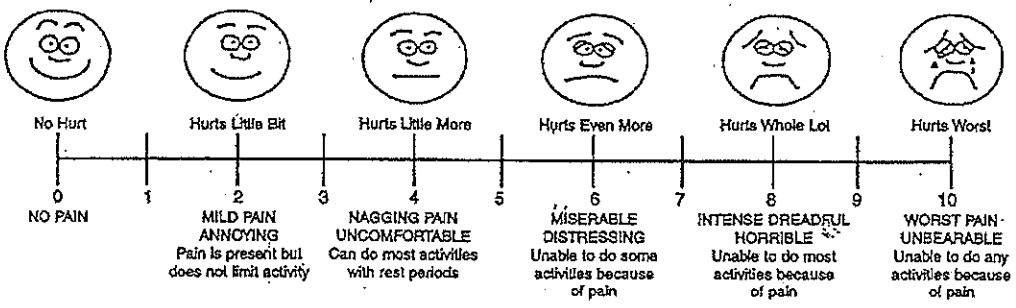
PATIENT INSTRUCTIONS: PLEASE INDICATE THE LOCATION, TYPE AND INTENSITY OF YOUR PAIN. USING SYMBOLS BELOW, SHOW WHICH AREA OF BODY THAT SYMBOLS EXIST.

000 pins & needles
xxx burning
/// stabbing
*** aching
— numbness





2. On the 0 - 10 pain scale and the Faces scale below, circle the number which best describes your pain.



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SIGNATURE DATE