CINCINNATI CHIROPRACTIC
CONFIDENTIAL INFORMATION

Today's Date_____/_____/_____ Name_____ Male / Female

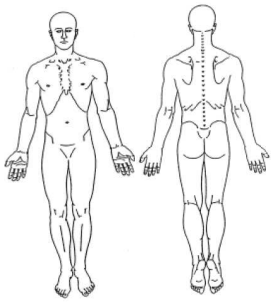
What you prefer to be called_____ SSN#_____-_____-_____
Home Phone (_____) _____-_____ Other Phone (_____) _____-_____
Street_____ City_____ Zip Code_____
Age_____ Birth Date_____/_____/_____ Marital Status: S-M-W-D How many Children_____

Occupation_____ Employer_____
Name of Wife/Husband_____ Spouse Employer_____
In Event of Emergency Nearest Relative_____ Relationship _____
Home Phone (_____) _____-_____ Office Phone (_____) _____-_____
How Did Your Hear About Our Office? _____
Email: _____ May We Send You Our E-Newsletter? Y/ N

CURRENT INSURANCE INFORMATION (Please provide card to be copied)
Ins. Company Name _____
Address _____
Insured's Name_____ Relation_____
Insured's Date of Birth_____/_____/_____ Phone# (_____) _____-_____
Insured's SS# or ID# _____ Insured's Employer _____
Group # (Plan, Local, or Policy #) _____ Co-Pay Amount: $_____
Do you have a Health Savings Account or Employer Spend Down Account?_____

REASON FOR VISIT:
Briefly explain in your own words: _____
_____
_____
Present Family Doctor: _____Last Seen: _____/_____/_____
Have you ever seen a Chiropractor before? Yes / No When? _____ How Often? _____
Please rate your pain on this scale:
No Pain 1***2***3***4***5***6***7***8***9***10 Extreme Pain At its Worst? __/10 Best? __/10

Where does it hurt?



AUTHORIZATION AND ASSIGNMENT
In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, adjuster or health care provider in order to process any claim for reimbursement of charges incurred or to appropriately co-manage care.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by insurance or my attorney out of the proceeds of any legal settlement of my case and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against such company (the names(s) of which is believed to be correctly set forth under insurance information and provided) and authorize you to prosecute said action either in my names as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. It is understood that reasonable efforts will be made to collect the sums due from the insurance company, or companies, contractually obligated. I do understand that whatever amounts you do not collect from insurance or settlement proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statue of limitations on collections and/or recovery in this state of Ohio
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed Cincinnati Chiropractic, LLC are paid in full.

Patient Signature _____ Date _____

CONFIDENTIAL HEALTH HISTORY

In general, would you say your health is (circle one): Excellent Very Good Good Fair Poor

PAST HEALTH HISTORY

1. Have you ever experienced your present problem before? Yes / No If yes, When? _____
2. Have you ever had any major illness, broken bones, hospitalizations, accidents, or surgeries? Yes / No
   If Yes, please explain (include dates):_____
   _____
   _____
3. Are you presently taking any prescriptions drugs, over-the-counter drugs, vitamins, or supplements? Yes / No
   If Yes, please list names with reason for taking and dosage: _____
   _____
   _____

FAMILY HISTORY/HEALTH: list any disease, disorder, or major illness. If deceased, from what?

1. Mother: _____
2. Father: _____
3. Sisters: _____
4. Brothers: _____
5. Other: _____

SOCIAL HISTORY: (Indicated as H-Heavy, M-Moderate, L-Low, N-None)

Sleep: H/M/L/N	Exercise H/M/L/N	Tobacco: H/M/L/N
Alcohol: H/M/L/N	Drugs: H/M/L/N	Appetite: H/M/L/N
Work Stress: H/M/L/N	Family Stress: H/M/L/N	

Education level (Circle): High School - Some college - College Graduate - Post Graduate - Other:_____

SYSTEM REVIEW QUESTIONS

Do you or have you ever had any problems with the following areas? (Please mark Y for yes and N for no in each of the following)

1. ____ Eyes	7. ____ Muscles	13. ____ Allergies
2. ____ Ears, Nose, Mouth, Throat	8. ____ Nerves	14. ____ Psychological/Emotional
3. ____ Heart	9. ____ Joints/Bones	**Female only:**
4. ____ Lungs/Breathing	10. ____Skin	15. ____ Gynecological/Menstrual
5. ____ Intestines/Bowels	11. ____ Internal Organs	**Male only:**
6. ____ Urinary	12. ____ Blood	16. ____ Prostate/Testicular

Please explain any above Yes answers:_____
_____
_____
_____

Female only (for purpose of X-Ray): Possibly pregnant? Yes / No

Thank you for providing us with the information that allows us to get to know you better. We take our work very seriously and want your experience with Cincinnati Chiropractic to be the best it can be. We only recommend treatment plans and order tests that we feel are ideal and appropriate for your needs. Every individual is different and requires an individual treatment approach. We take a hard-working TEAM approach at Cincinnati Chiropractic and hope and expect that you offer the same. Please consider the following so we can best suit your plan for optimal health: (Please Indicate Your Answer With an "X".)

Do you hope to: __ Get Temporary Pain Relief __ Fix the Problem
Are you willing to follow an in-office and home exercise plan? __ Yes __ No

We work well with Medical Doctors, Surgeons, etc. who also work hard for your well-being. Occasionally, with your approval, we will send them a brief report keeping them current with your health. __ Yes, Do __ No, Don't

Signature: _____ Date: _____