METHOD HEALTH CENTER

File#_____

Last Name: _____MI:_____ First Name: _____

Home Address: _____City: _____

State: _____ Zip: _____Home Telephone: _____Cell Phone:_____

Notify in case of emergency: _____ Tel:_____

Date of Birth: _____/_____/_____ Sex: ____F ____M Soc. Sec. #: _____/_____/_____

Marital Status: S M W D Age: _____ E-mail:_____

Race:_____Ethnicity:_____Children (ages):_____

Employer: _____ Occupation:_____Work Phone: _____

How did you hear about our office?_____

METHOD OF PAYMENT (Circle Choice)

Self-Pay: Cash / Check / Credit Card / Private Insurance / Medicare

Date of Injury:____/_____/__Work Comp / Accident Attorney / Other:_____

INSURANCE INFORMATION

*Insured Name(if other than patient)*_____ *Insured Subscriber #:*_____
*Insured Date of Birth:*_____ *Soc. Sec # of insured*:_____
Medical Insurance _____ Subscriber Number:_____
Policy#: _____ Group#: _____ Tel of Insurance:_____
Address: _____
****

Worker's Comp/ Auto accident / Attorney: _____

Claim #:_____ Adjuster: _____

Address: _____City: _____ State: _____ Zip:_____

Tel: _____Fax:_____

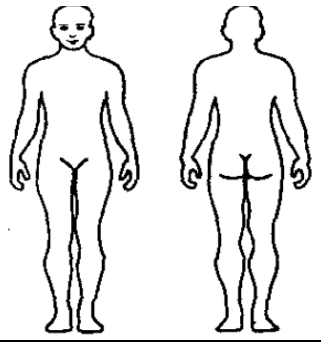
ASSIGNMENT OF INSURANCE BENEFITS / PATIENT INFORMATION

I hereby instruct and direct my insurance company to pay by check made out and mailed to **METHOD HEALTH CENTER**, the professional and medical expense benefits allowable under my current insurance policy for services rendered to me or my dependent. This is a direct assignment of my rights and benefits under this policy. A photocopy of this Agreement shall be considered as effective and valid as the original. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information of this sheet and have completed the above answers I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient or Beneficiary_____Date:_____

Area of Complaint/Condition_____
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 □ Weakness □ 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
What makes the problem(s) worse ___Sitting ___Standing ___
Walking ___Bending ___Lying down_____

Mark Symptoms



What makes the problem(s) better _____
What treatments have you already received for this condition? _____Medications _____ Surgery _____Physical Therapy
_____Chiropractic Services _____ None _____Other/ Home Treatment_____
Name and Phone Number of other doctor(s) who have treated you for your condition_____
_____
Date of Last: Physical Exam_____ Spinal X-Ray_____ MRI/CT Scan_____

Place a mark on yes or no to indicate if you have or had any of the following:

Aids/HIV	□Yes □No	Epilepsy	□Yes □No	Memory Loss	□Yes □No	Fever or Chills	□Yes □No
Alcoholism	□Yes □No	Fatigue	□Yes □No	Miscarriage	□Yes □No	Shortness of Breath	□Yes □No
Allergy Shots	□Yes □No	G.I. problems	□Yes □No	Migraine Headaches	□Yes □No	Sleep Difficulty	□Yes □No
Anemia	□Yes □No	Glaucoma	□Yes □No	Diarrhea	□Yes □No	Stroke	□Yes □No
Skin Condition(s)	□Yes □No	Goiter	□Yes □No	Mononucleosis	□Yes □No	Suicide Attempt	□Yes □No
Appendicitis	□Yes □No	Neck Pain	□Yes □No	Multiple Sclerosis	□Yes □No	Thyroid Problems	□Yes □No
Arthritis	□Yes □No	Hiatal Hernia	□Yes □No	Weight Loss/Gain	□Yes □No	Tingling	□Yes □No
Asthma	□Yes □No	Headaches	□Yes □No	Nausea	□Yes □No	Tonsillitis	□Yes □No
Bleeding Disorders	□Yes □No	Hearing Difficulty	□Yes □No	Nervousness	□Yes □No	Tuberculosis	□Yes □No
Bowel Problems	□Yes □No	Heart Burn	□Yes □No	Numbness	□Yes □No	Tumors, Growths	□Yes □No
Breast Lump	□Yes □No	Heart Disease	□Yes □No	Osteoporosis	□Yes □No	Dizziness	□Yes □No
Bronchitis	□Yes □No	Hepatitis	□Yes □No	Pacemaker	□Yes □No	Ulcers	□Yes □No
Anorexia/Bulimia	□Yes □No	Hernia	□Yes □No	Parkinson's Disease	□Yes □No	Muscle/Joint Pain	□Yes □No
Cancer	□Yes □No	Herniated Disc	□Yes □No	Pinched Nerve	□Yes □No	Urinary Changes	□Yes □No
Cataracts	□Yes □No	Change in Appetite	□Yes □No	Pneumonia	□Yes □No	Vaginal Infections	□Yes □No
Chemical		High Blood Pressure	□Yes □No	Polio	□Yes □No	Venereal Disease	□Yes □No
Dependency	□Yes □No	High Cholesterol	□Yes □No	Problems with Eyes		Vomiting	□Yes □No
Chest Pain	□Yes □No	Itching	□Yes □No	Ears, Nose, Throat	□Yes □No	Weakness	□Yes □No
Chicken Pox	□Yes □No	Kidney Disease	□Yes □No	Prostate Problems	□Yes □No	Whooping Cough	□Yes □No
Depression	□Yes □No	Liver Disease	□Yes □No	Prosthesis	□Yes □No		□Yes □No
Diabetes	□Yes □No	Swelling of Joints	□Yes □No	Psychiatric Care	□Yes □No	Other_____	
Constipation	□Yes □No	Loss of Concentration	□Yes □No	Rheumatoid Arthritis	□Yes □No		
Emphysema	□Yes □No	Cough	□Yes □No	Bruising	□Yes □No	_____	

Exercise
□ None
□ Moderate
□ Daily
□ Heavy

Work Activity
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits
Right or Left Handed_____
□ Smoking Packs/Day_____
□ Alcohol Drinks/Day_____
□ Coffee/Caffeinated drinks Cups/Day_____
□ High Stress Level Reason_____

Are you pregnant? □ Yes □ No Due date_____

	Description	Date
Accidents/Workers Comp/ Car Accidents	_____	_____
Falls/ Injuries	_____	_____
Broken Bones / Dislocations	_____	_____
Surgeries	_____	_____