

# Genesis Back & Neck

## Patient History

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F SSN# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Married  Single  Divorced  Widow/Widower

Spouses Name \_\_\_\_\_ Children's Names and Ages \_\_\_\_\_

Name of Health Insurance \_\_\_\_\_

Insured Person's Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Health Insurance  Auto Insurance  Medicare  Other

Emergency contact phone number \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Patient Referral Patient Name: \_\_\_\_\_

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Have you received any of the following?  Acupuncture  Chiropractic  Physical Therapy  
 Massage  Pain Management  Other: \_\_\_\_\_

When were your most recent surgeries? \_\_\_\_\_

What were they for? \_\_\_\_\_

List all drugs you are taking (including prescription and non-prescription drugs, such as birth control, aspirin, heart medication, laxatives, cold tablets, allergy medication, etc...)

Medication \_\_\_\_\_ Purpose \_\_\_\_\_

Medication \_\_\_\_\_ Purpose \_\_\_\_\_

Medication \_\_\_\_\_ Purpose \_\_\_\_\_

Medication \_\_\_\_\_ Purpose \_\_\_\_\_

For Females Only

Date of last cycle: \_\_\_\_\_ Is there any chance that you might be pregnant?  Yes  No

Please indicate which of the conditions below you have experienced?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acid Reflux        | <input type="checkbox"/> Ear Infection        | <input type="checkbox"/> Rheumatism     |
| <input type="checkbox"/> ADD/ADHD           | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Scarlet Fever  |
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> German Measles       | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Headaches/Migraines  | <input type="checkbox"/> Sinus Trouble  |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Tired/Fatigued |
| <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Bladder            | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> V.D.           |
| <input type="checkbox"/> Bone Fracture      | <input type="checkbox"/> Indigestion          | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Bowel Control Loss | <input type="checkbox"/> Kidney Disorder      |   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Menstrual Cramps     |   |
| <input type="checkbox"/> Carpel Tunnel      | <input type="checkbox"/> Multiple Sclerosis   |   |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Multiple Dystrophy   |   |
| <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> Neck Pain            |   |
| <input type="checkbox"/> Concussion         | <input type="checkbox"/> Nervousness          |   |
| <input type="checkbox"/> Cramping           | <input type="checkbox"/> Numbness             |   |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Polio                |   |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Poor Circulation     |   |
| <input type="checkbox"/> Dislocated Joints  | <input type="checkbox"/> Reproductive Trouble |   |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Rheumatic Fever      |   |

Have either of your parents experienced any of the above conditions? \_\_\_\_\_

\_\_\_\_\_

Which of the above conditions bothers you the most? \_\_\_\_\_

Which of the above conditions do you hope will be helped in our office?

\_\_\_\_\_

I understand that Genesis Back and Neck may notify me by phone.

I understand all treatments, x-rays and examinations are to be paid for as they are received or there has been a definite financial arrangement made in advance.

Assignment of Benefits: I authorize the release of any medical or other information necessary to process this claim in order to receive payment from insurance carriers.

**Patients Signature** \_\_\_\_\_ **Date** \_\_\_\_\_