

# Flynn Chiropractic and Sports Rehabilitation

## Confidential Patient Information

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Email \_\_\_\_\_ Would you like to receive our free health e-newsletter? Y N  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status M S W D How many Children? \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Spouse \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_  
 Who can we thank for referring you to our office? \_\_\_\_\_ Called Name \_\_\_\_\_

### Reason for Visit

Have you ever been treated by a Chiropractor before?

Yes  No

The reason for this visit is a result of (circle one):

Work Sports Auto Trauma Chronic

Explain: \_\_\_\_\_  
 \_\_\_\_\_

When did the condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the condition getting worse?

Yes  No  Constant  Comes and goes

Other doctors seen for this condition: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

### Medical History

Date of last Physical Examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

(women) Are you Pregnant?  Yes  No

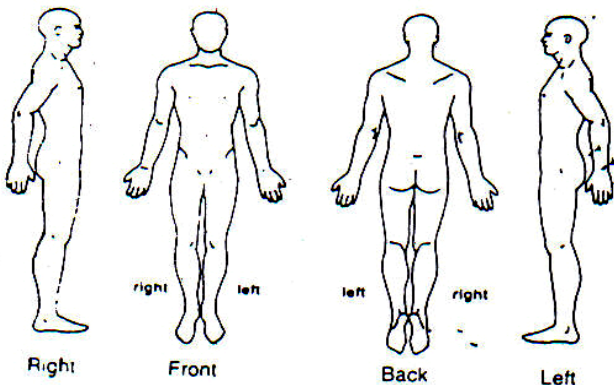
Have you ever suffered from/do you have:

Anemia     Diabetes     Nervousness  
 Asthma     Digestive Disorders     Sinus Trouble  
 Arthritis     Dizziness     Sleeping Trouble  
 Artificial Bones/Joints/Implants     Tuberculosis  
 Backaches     Fatigue  
 Cancer     Headaches  
 Constipation     Heart Trouble

Explain: \_\_\_\_\_  
 \_\_\_\_\_

Please mark area(s) of pain or discomfort on the figures below.

(----) Numbness    (+++++) Burning    (oooo) Stabbing  
 (XXXX) Aching    (OOOO) Pins and Needles



### Insured Information

Name of Insured if other than Patient: \_\_\_\_\_

Relation of Insured to Patient: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize payment directly to Dr. John Flynn of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on behalf of my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
 Signature of Responsible Party / Date