

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: _____

Insured Information

Name of Insured if other than Patient: _____

Relation of Insured to Patient: _____

Insured Employer: _____

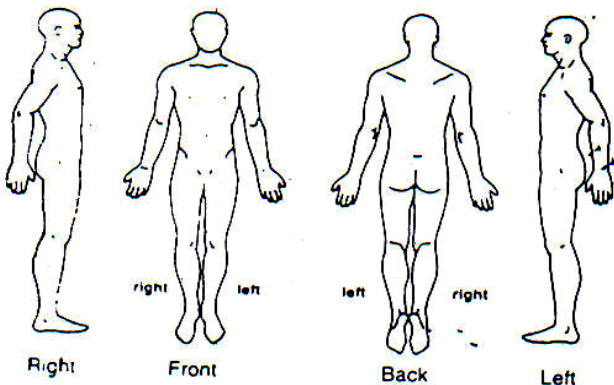
Date of Birth: ____/____/____

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

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

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



Accidental Injury Information

Date of Accident _____ Hour _____ am/pm Location _____

How did the accident occur? _____ Auto accident _____ On the job injury _____ Other _____

If not an auto accident, please describe the circumstances: _____

Industrial Accident:

Did you report the injury to your foreman or employer? Y N Individual's Name _____

Did he (they) recommend care at our office? Y N Have you seen another doctor for your injury? Y N

Auto Accident:

You were the: _____ Driver _____ Passenger _____ Front Seat _____ Back Seat _____ Pedestrian

Vehicle was struck from: _____ Behind _____ Right Side _____ Left Side _____ Front _____ Auto was Parked

Weather Conditions: _____ Using Seatbelts? Y N

Did your car strike the other(s) involved? Y N OR Did the other car strike yours? Y N

As a result of the accident were traffic citations issued to you? Y N To the driver of the other car? Y N

To the driver of the car you were a passenger of? Y N Please describe the accident: _____

List the extent of injuries as you know them: _____

Did you require post-accident hospitalization? Y N Where? _____

Check any symptoms you have noticed since the accident:

_____ Back Pain	_____ Face Flushed	_____ Lights bother Eyes	_____ Numbness in Toes
_____ Buzzing in Ears	_____ Fainting	_____ Loss of Balance	_____ Pins & Needles in Arms
_____ Chest Pain	_____ Fatigue	_____ Loss of Memory	_____ Pins & Needles in Legs
_____ Cold Sweats	_____ Feet Cold	_____ Loss of Smell	_____ Shortness of Breath
_____ Constipation	_____ Fever	_____ Loss of Taste	_____ Sleeping Problems
_____ Depression	_____ Hands Cold	_____ Neck Pain	_____ Stomach Ache
_____ Diarrhea	_____ Head seems Heavy	_____ Neck Stiff	_____ Tension
_____ Dizziness	_____ Headaches	_____ Nervousness	_____ Other
_____ Ears Ringing	_____ Irritability	_____ Numbness in Fingers	Please Explain: _____

Did you have any symptoms prior to injury? Y N Which symptoms? _____

Have you previously injured the area of today's chief complaint? Y N

Have you been treated for any health condition by a physician in the last year? Y N

Have you lost any days of work? Y N Dates: _____

Insurance Companies Involved:

My Company: _____

Company of Responsible Party: _____

Have you been contacted by and insurance adjuster or company representative regarding this claim? Y N

Have you hired an Attorney? Y N

Other Doctors Seen for this Injury:

Dr. Name: _____ Diagnosis: _____ X-rays? Y N

Urinalysis? Y N Blood Tests? Y N Prescribed Drugs? Y N What? _____

Shots? Y N Traction? Y N Physiotherapy? Y N Other: _____

Results: _____

Length of time under care of this Physician: _____ History of Prior Injury, Illness or Surgery: _____