

PATIENT INTRODUCTION FORM

Date: _____	Social Security Number: _____
Name: _____	Phone No. (Home): _____ (Work): _____
Address: _____	Date of Birth: _____ Marital Status: _____
City: _____	Name of Spouse, Children: _____
State: _____ ZIP: _____	Occupation/Profession: _____
Email: _____	Employer: _____
Allergies: _____	Medications: _____
Smoker? _____	Frequency: _____

Briefly describe complaints: _____

Are these related to: Auto Accident Work Injury None Other: _____

Referred by: _____

Have you had previous chiropractic care? Yes No Where: _____

Do you have health insurance? Yes No Name of company: _____

DO YOU HAVE DIFFICULTY WITH THE FOLLOWING? IF YES, PLEASE MARK NEXT TO THAT ISSUE.

Dizziness	<input type="checkbox"/>	Shooting Head Pains	<input type="checkbox"/>	Nervous Stomach	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	Numbness in Arms	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Grating in Neck	<input type="checkbox"/>	Wear Glasses/Contacts	<input type="checkbox"/>	Numbness in Hands	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Hay Fever/Allergies	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Low-Back Pain	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Shoulder Pain/Tightness	<input type="checkbox"/>	Menstrual Cramps/Pain	<input type="checkbox"/>
Head Feels Heavy	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	Tingling in Arms	<input type="checkbox"/>	Numbness in Feet	<input type="checkbox"/>
Light Bothers Eyes	<input type="checkbox"/>	Heart Attacks	<input type="checkbox"/>	Tingling in Hands	<input type="checkbox"/>	Numbness in Legs	<input type="checkbox"/>
Loss of Balance	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Bladder Control	<input type="checkbox"/>	Pain in Legs/Feet	<input type="checkbox"/>
Loss of Smell	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Pinched Nerves	<input type="checkbox"/>
Muscle Spasm in Neck	<input type="checkbox"/>	Mid-Back Pain	<input type="checkbox"/>	Disc Problems	<input type="checkbox"/>	Tingling in Feet	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	Tingling in Legs	<input type="checkbox"/>
Ringling in Ears	<input type="checkbox"/>						

PATIENT AGREEMENT ASSIGNMENT AND RELEASE

I, the undersigned assign directly to Matoshko Chiropractic Clinic, P.L.L.C., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: _____