Welcome

Patient Information

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

City ______________________

State ____________ Zip ____________

E-mail ______________________

Sex ☐ M ☐ F Age ____________

Birthdate ______________________

☒ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______________________

Patient Employer/School ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

Insurance

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ____________ SS# ____________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr. Abraham Sadon ______________________ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

Phone Numbers

Home Phone (_____) ______________________

Cell Phone (_____) ______________________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________

Relationship ______________________

Home Phone (_____) ______________________

Work Phone (_____) ______________________

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date ______________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

____

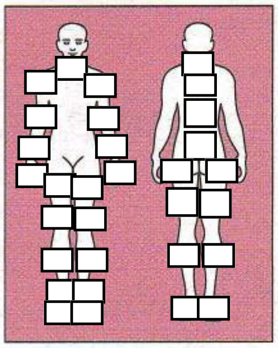
Patient Condition

Reason for Visit ______________________

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 ☐ 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

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

◯ Chiropractic Services ◯ None ◯ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Chicken Pox	☐Yes ☐No	Liver Disease	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Alcoholism	☐Yes ☐No	Diabetes	☐Yes ☐No	Measles	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Emphysema	☐Yes ☐No	Migraine Headaches	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Anemia	☐Yes ☐No	Epilepsy	☐Yes ☐No	Miscarriage	☐Yes ☐No	Stroke	☐Yes ☐No
Anorexia	☐Yes ☐No	Fractures	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Suicide Attempt	☐Yes ☐No
Appendicitis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Arthritis	☐Yes ☐No	Goiter	☐Yes ☐No	Mumps	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Asthma	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Gout	☐Yes ☐No	Pacemaker	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Breast Lump	☐Yes ☐No	Heart Disease	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No	Typhoid Fever	☐Yes ☐No
Bronchitis	☐Yes ☐No	Hepatitis	☐Yes ☐No	Pinched Nerve	☐Yes ☐No	Ulcers	☐Yes ☐No
Bulimia	☐Yes ☐No	Hernia	☐Yes ☐No	Pneumonia	☐Yes ☐No	Vaginal Infections	☐Yes ☐No
Cancer	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Polio	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Cataracts	☐Yes ☐No	Herpes	☐Yes ☐No	Prostate Problem	☐Yes ☐No	Whooping Cough	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Prosthesis	☐Yes ☐No	Other _____
		Kidney Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	_____

EXERCISE

☐ None
☐ Moderate
☐ Daily
◯ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone (____) _____		