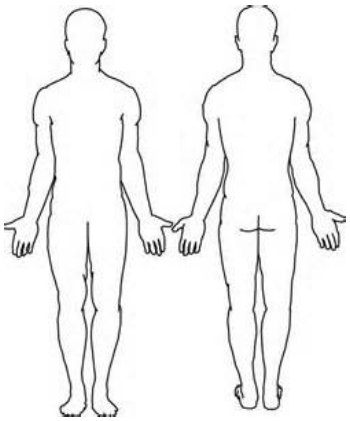
COWART CHIROPRACTIC
LIVING WELL FOR LIFE

Welcome to our office. Please take a moment to complete the following forms.
Please let us know if you need any assistance, or have a question.

Patient Name_____Birthdate_____M/F
Address_____City_____
State_____Zip_____Phone (___) _____Email_____
Marital Status_____ Occupation_____
Employer_____Address_____
Subscriber Name_____Health Plan_____
Subscriber ID#_____Group#_____Spouse Name_____
Spouse Employer_____City_____State_____Zip_____
Primary Care Physician Name_____Phone_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Describe your current problem and how it began:
__Headache __Neck Pain __Mid-Back Pain __Low Back Pain __Other_____
Is this? __Work related ___Auto related ___Gradual onset ___N/A
Date problem/pain began_____How problem/pain began_____
Current pain level: (How you feel today)

|_____|
0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable pain

How often are your symptoms present? __0-25%, __26-50%, __51-75%, __76-100%

In the past week, how much pain interfered with your daily activities, such as work, social activities and/or household chores?

|_____|
0 1 2 3 4 5 6 7 8 9 10
No interference Unable to carry on any activities

Does the pain radiate? Yes/No If yes, where_____

Have you had Chiropractic care? _____ If yes, for what?_____
When?_____Doctor's name_____
Have you had spinal x-rays, MRI, CT scan for your area(s) of complaint? Yes/No
Date taken_____What areas were taken?_____

What makes your problem **better**? ___Nothing ___Lying down ___Walking ___Sitting
____Movement/Exercise _____Inactivity
What makes your problem **worse**? ___Nothing ____Lying down ___Walking ___Sitting
_____Movement/Exercise _____Inacitivity

Is your pain affecting your ability to be active? __No affect __Some physical restrictions
__Need limited assistance with common everyday tasks ___Need assistance often
__Have a significant inability to function without assistance ___Totally disabled more than 50%

Physical activity at work? __Sitting more than 50% of work day __Light manual labor
__Heavy manual labor ___Repeated motion

How would you rate your stress? __Little/no stress __Minimal __Moderate __Greatly stressed

Please check all of the following that apply to you:

__Alcohol/Drug dependence	__Tobacco, ___type	__Recent fever
__Menstual problems	__Diabetes	__Urinary problems
__High blood pressure	__Stroke	__Corticosteroid Use
__Currently pregnant, week #__	__Abnormal weight gain	__Abnormal weight loss
__Taking birth control pills	__Dizziness/Fainting	__Morning pain/stiffness
__Numbness in groin/buttocks	__Visual disturbances	__Pain at night
__Pain unrelieved by position/rest	__Osteoporosis	__Prostrate problems
__Epilepsy/Seizures	__Medications_____	

__Cancer/tumor Explain_____
Other health problems_____

Family History: __Cancer __Diabetes __High Blood Pressure __Heart Problems
__Stroke __Rheumatoid Arthritis

Accident Information:

Is your condition due to an accident? Yes/No _____date of accident
Type of accident __Auto __Work __Home __Other, please describe_____
What treatment have you already received for your condition? __Medication __Surgery
__Physical Therapy __Chiropractic __None __Other_____
Name and address of other doctor(s) who have treated you for this condition_____
_____
Date of last physical exam_____Blood work_____MRI_____

To whom have you made a report of your accident? __Auto insurance __Employer __Workman's Compensation __Other_____

Attorney name and phone_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive healthcare benefits through this provider, I understand I am liable for all charges for services rendered. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that Cowart Chiropractic may need to contact my physician if my condition needs to be co-managed. Therefore, I give my authorization to Cowart Chiropractic to contact my physician if necessary.

Patient's signature_____date_____

If patient is under 18 years of age, parent/guardian signature_____ date_____