WOOTTON
| Family Chiropractic |

680 N. Germantown Parkway, Suite 44. Cordova, TN. 38018 (901) 207-3247

Name_____Today's Date_____

Address_____City_____St._____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Email Address_____

Date of Birth_____ Age_____ Social Security Number_____

Marital Status (circle one) M S D W Spouse's Name__ _____Number of Children____

Occupation_____Employer_____

Work Address_____

How did you hear about us?_____

Have you ever had chiropractic care before? Y N Date_____

Insurance

Primary Insurance Company_____Subscriber ID#_____

Secondary Insurance Company_____Subscriber ID#_____

Account Information

All charges are due when services are rendered. Method of Payment: ( ) Cash ( ) Check ( ) Credit Card

_____ (Please Initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance.

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Describe your <u>current</u> problem and how it began.

( ) Headache ( )Neck Pain ( )Mid Back Pain ( ) Low Back Pain ( )Other

Date problem began_____

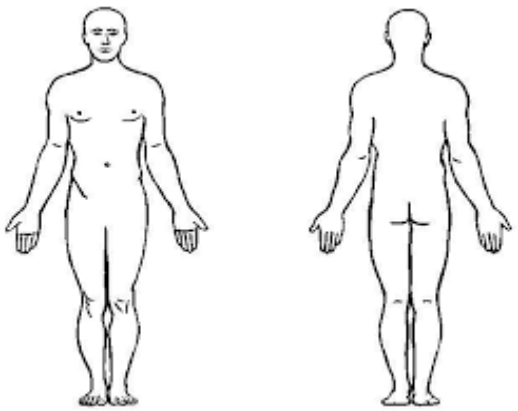
How problem began_____

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

Complete Side 2

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Unbearable	Miserable	Exhausting
Stabbing	Tiring	Gnawing



Please mark an **X** on the picture where you have pain or other symptoms.

Rate your pain by circling the number that best describes your pain RIGHT NOW.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable.

What makes your pain <u>BETTER?</u> _____

What makes your pain <u>WORSE?</u> _____

How often are your symptoms present?

(Occasional) ( ) 0-25% ( ) 26-50% ( ) 51-75% ( ) 76-100% (Constant)

Is this? ( ) Work-Related ( ) Auto-Related ( ) Neither

Please list ALL MEDICATIONS you are currently taking.

_____

Please list any surgeries you have had.

_____

Check any of the following you have had in the last six months:

( ) Headaches	( ) Blood Pressure Problems	( ) Constipation/ Diarrhea
( ) Sinus Congestion / Allergies	( ) Ankle Swelling	( ) Discolored Urine
( ) Vision Problems	( ) Prostate/ Sexual Dysfunction	( ) Poor / Excessive Appetite
( ) Earaches	( ) Menstrual Cycle Dysfunction	( ) Excessive Thirst
( ) Dizziness	( ) Numbness	( ) Painful/ Excessive Urination
( ) Heart Problems	( ) Frequent Nausea/ Vomiting	( ) Cancer
( ) Lung Problems	( ) Abdominal Cramps	( ) Diabetes

I authorize Wootton Family Chiropractic to render necessary services to me and I am responsible for all charges incurred.

Patient Signature_____ Date_____

Parent/Guardian Signature_____