Office Use Only
PATIENT ID_____

DR._____

WOOTTON
| Family Chiropractic |

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

Name_____Today's Date_____

Address_____City_____St._____Zip_____

Best Phone Number to Reach You_____ E-mail Address_____

Date of Birth_____ Age:_____ Sex: ( ) Male ( ) Female Number of Children_____

Employer_____Occupation_____

Marital Status (circle one) M S D W

Spouse's Name__ _____

How did you hear about us?_____

Have you ever had chiropractic care before? Y N Date_____

Insurance Information

Primary Insurance Company_____

* We will make a copy of your insurance card.

Social Security Number_____ (for insurance filing)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered
(Please Initial)

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Mark next to your CURRENT problem(s).

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

Date problem began_____

How problem began_____

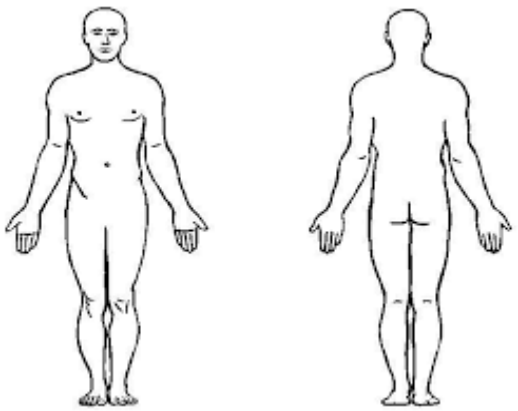
Is this auto related? YES or NO

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

Please Complete Back Side

Circle all of 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.

Circle 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)

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/ Guardian Signature_____Date_____