

Welcome

Patient Information

Date: _____
Patient: _____
Address: _____
City _____ State _____ Zip _____
Email Address: _____
Do you want our newsletter emailed? Yes No
Do you want your bill (if any) emailed? Yes No
Patient's Home Phone #: _____
Cell: _____ Work: _____
Sex: M F Age _____ Birth date _____
 Single Married Widowed Separated Divorced
Patient's SS#: _____
Occupation: _____
Employer: _____
Employer Address: _____

Spouse's Name: _____
Birth date: _____
Occupation: _____
Spouse's Employer: _____
Whom may we thank for referring you? _____

Phone Numbers

Best time and place to be reached? _____

In Case of an Emergency, Contact:

Name: _____ Relationship: _____
Home: _____ Cell: _____

Insurance

Who is responsible for this account? _____
Relationship to Patient: _____
Insurance Co: _____
Insurance ID #: _____
Group #: _____
Is Patient covered by Additional Insurance? Yes No
Subscriber's Name: _____
Birth date: _____ SS#: _____
Relationship to Patient: _____
Insurance Co: _____
Insurance ID#: _____
Group #: _____

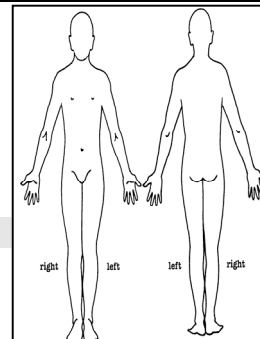
Assignment and Release:

I, the undersigned certify that I (or my dependent) have Insurance coverage with _____
And assign directly to Dr. George T Cunningham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges including durable medical equipment and supplements whether or not paid by insurance. If the account goes to collections, I understand that I am responsible for any and all collection fees. I hereby authorize the doctor to release all information necessary to secure the benefits. I authorize the use of payment of this signature on all insurance submissions.
Responsible Party Signature: _____
Relationship: _____ Date: _____

Patient Condition:

Reason for your visit: _____
When did your symptoms appear? _____
Is this condition getting progressively worse? Yes No Unknown
Are you presently working? Yes No
Rate the severity of your pain on a scale from 1 (least pain) to 10 (sever 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? _____
Have you ever seen a chiropractor before: Yes No

Mark an X on the picture
where you continue to have
pain numbness, or tingling



Managed Case Waiver: Only fill out if referral is needed

I have been informed and understand that my insurance plan requires a referral from my primary care physician (PCP). I also understand without a referral my insurance will not authorize payment for services rendered or charged to me. Dr. Cunningham and his staff have informed me that they have not received a referral from my PCP. Since I still wish to Be treated I agree to pay in full any and all charges related to the Services rendered to me.
Patient's Signature: _____ Date: _____ Witness: _____

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: _____

Height: _____ Weight: _____

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

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

Primary Care Physician Name: _____

Address: _____ City: _____

State, Zip: _____ Phone #: _____

Would you like Dr. Cunningham's notes sent to this physician: Yes No

Exercise: None Moderate Daily Heavy	Work Activity: Sitting Standing Light Labor Heavy Labor	Habits: Smoking Alcohol Coffee/Caffeine Drinks High Stress Level	Packs/Day: _____ Drinks/Week: _____ Cups/Day: _____ Reason: _____
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Are you pregnant? Yes No Due Date: _____

Injuries/Surgeries you have had

Falls: _____ Date: _____

Head Injuries: _____ Date: _____

Broken Bones: _____ Date: _____

Dislocations: _____ Date: _____

Surgeries: _____ Date: _____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____