Cunningham Chiropractic Welcome To Our Office

Date: _____/_____/_____

Patient Information

Patient: _____

Address: _____

City_____State_____Zip_____

Statement Emailed? ☐Yes ☐No IF YES EMAIL BELOW
Email Address: _____

Appt. Reminders☐ Yes ☐ No Cell Phone Carrier:_____

Patient's Home Phone:_____

Patient's Cell Phone: _____

Patient's Work Phone: _____

Sex: ☐M ☐F Age _____ Birth date _____/_____/_____
☐Single ☐Married ☐Widowed ☐ Separated ☐Divorced

Patient's SS#: _____-_____-_____

Occupation: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name:_____

DOB: _____ /_____ /_____ Occupation: _____

Spouse's Employer: _____

Phone Numbers Fill Out Information Below

If minor who do we contact regarding insurance information:

Name: _____ Ph: (____) _____- _____

In Case of an Emergency, Contact:

Name: _____ Relationship: _____

Home: (____) _____- _____Cell: (____) _____- _____

****Whom May We Thank for Referring You to Our Office****

Name:_____**

Primary Insurance

Who is subscriber:_____Insured's DOB ___/___/____

Insurance Co: _____

Insurance ID #: _____

Group #: _____ **SSN of insured: _____-_____-_____**

Is Patient covered by Additional Insurance? ☐ Yes ☐ No

Secondary Ins: _____DOB___/____/____

ID#: _____Group#:_____

Third Insurance: _____

Name of NF/WC Ins Carrier: _____

Workers Comp Clm#:_____

No-Fault Clm#:_____

Date of Injury:_____/_____/_____

Assignment and Release:

I, the undersigned certify that I (or my dependent have insurance coverage with _____and assign directly to Dr. George Cunningham all insurance benefits, if any, otherwise payable to me for services rendered. I know 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 this signature on all insurance submissions. **I also understand a quote of benefits does not guarantee payment.** Payment of insurance benefits are subject to terms, limitation, and the plan exclusions at the time services are rendered.

Responsible Party Signature: _____

Relationship: _____ Date: _____/____/_____

Patient Symptoms and Other Information Below

Reason for your visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Are you presently working? ☐Yes ☐No if no last date worked _____/_____/_____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

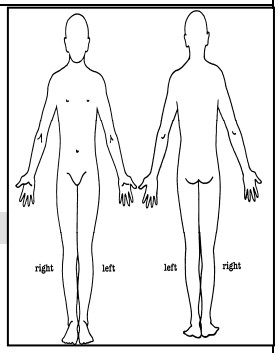
Circle type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

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 if yes, Whom: _____

Is this a result of a Workers Comp Injury? ☐ Yes ☐ No ***Is this a result of a No-Fault Injury?*** ☐ Yes ☐No



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

Managed Case Waiver: *ONLY FILL OUT IF YOUR INSURANCE REQUIRES A REFERRAL*

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: _____

----------Complete Back Side----------→

Health History

Height: _____ Weight: _____ Blood Pressure: _____ Last Spinal Exam: _____ MRI: _____
Last Physical Exam: _____ CT: _____ Scan Bone Scan: _____ Spinal X-Ray: _____
What treatment have you already received for your condition? ☐ Medications ☐Surgery ☐Physical Therapy ☐Massage
☐Chiropractic Services ☐ None ☐ Other _____
Name and address of other doctor(s) who have treated you for your condition: _____
_____

Check Box "Yes or "No" to indicate if you have had any of the following: Check Box F to indicate family history of the following:

AIDS/HIV Yes☐ No☐ F☐
Alcoholism Yes ☐ No☐ F☐
Allergy Shots Yes☐ No ☐ F☐
Anemia Yes☐ No ☐ F☐
Anorexia Yes☐ No ☐ F☐
Appendicitis Yes☐ No ☐ F☐
Arthritis Yes ☐ No ☐ F☐
Asthma Yes☐ No ☐ F☐
Bleeding Yes☐ No ☐ F☐
Disorders Yes☐ No ☐ F☐
Breast Lump Yes☐ No ☐ F☐
Bronchitis Yes☐ No ☐ F☐
Bulimia Yes☐ No ☐ F☐
Cancer Yes☐ No ☐ F☐
Chicken Pox Yes ☐ No ☐ F☐
Cataracts Yes☐ No ☐ F☐
Chemical Dependency Yes☐ No☐ F☐
Emphysema Yes☐ No ☐ F☐
Epilepsy Yes☐ No ☐ F☐
Fractures Yes☐ No ☐ F☐
Glaucoma Yes☐ No ☐ F☐
Goiter Yes ☐ No ☐ F☐
Diabetes Yes☐ No ☐ F☐
Gonorrhea Yes☐ No ☐ F☐
Gout Yes ☐ No ☐ F☐
Heart Disease Yes☐ No ☐ F☐

Hepatitis Yes☐ No☐ F☐
Hernia Yes☐ No☐ F☐
Herniated Disk Yes☐ No☐ F☐
Herpes Yes ☐ No☐ F☐
High Cholesterol Yes☐ No☐F☐
Kidney Disease Yes☐ No☐ F☐
Liver Disease Yes☐ No☐ F☐
Measles Yes☐ No☐ F☐
Miscarriage Yes☐ No☐ F☐
Mononucleosis Yes☐ No☐ F☐
Multiple Sclerosis Yes☐ No☐F☐
Mumps Yes☐ No☐F☐
Osteoporosis Yes☐ No☐ F☐
Pacemaker Yes☐ No ☐ F☐
Parkinson's Disease Yes☐ No☐ F☐
Pinched Nerve Yes☐ No☐F☐
Pneumonia Yes ☐ No☐F☐
Polio Yes ☐ No ☐ F☐
Prostate Problems Yes ☐ No☐ F☐
Psychiatric Care Yes ☐No ☐F☐
Rheumatoid Arthritis Yes☐ No☐ F☐
Migraines Yes☐ No ☐ F☐
Rheumatic Fever Yes ☐No ☐F☐
Allergy to heat/cold Yes☐ No ☐

Scarlet Fever Yes ☐ No ☐ F☐
Stroke Yes ☐ No ☐ F☐
Suicide Attempt Yes ☐ No ☐ F☐
Thyroid Problems Yes ☐ No ☐F☐
Tonsillitis Yes ☐ No ☐ F☐
Tuberculosis Yes☐ No ☐ F☐
Tumor Growths Yes ☐ No ☐ F☐
Typhoid Fever Yes ☐ No ☐ F☐
Ulcers Yes ☐ No☐ F☐
Vaginal Infections Yes ☐ No ☐ F☐
Venereal Disease Yes ☐ No ☐
Whooping Cough Yes ☐ No☐ F☐
Are you pregnant? Yes ☐ No ☐ Due Date:_____
Other: _____
_____
Number of Children:_____

Any Prior History of Neck or Back Injuries: ☐ Yes ☐ No
If Yes, Explain: _____
_____

Primary Care Physician Name: _____
Address: _____**City:** _____**State:** _____**, Zip:**_____
Phone #: _____-_____-_____ **Would you like Dr. Cunningham's notes sent to this physician:** Yes☐ No☐
Would you like Dr. Cunningham's office to send notes to another provider: Yes☐ No ☐
Would you like a Clinical Summary of your visit emailed to you? Yes☐ No ☐ if yes: email: _____

Exercise:	**Work Activity:**	**Habits:**	
None ☐	Sitting☐	Smoking ☐	Packs/Day: _____
Moderate☐	Standing☐	Alcohol ☐	Drinks/Week: _____
Daily☐	Light Labor☐	Coffee/Caffeine Drinks ☐	Cups/Day: _____
Heavy☐	Heavy Labor☐	High Stress Level ☐	Reason: _____

Injuries/Surgeries you have had

Falls: _____ **Date:** _____
Head Injuries: _____ **Date:** _____
Broken Bones: _____ **Date:** _____
Dislocations: _____ **Date:** _____
Surgeries: _____ **Date:** _____

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