

**PATIENT INFORMATION**

Date \_\_\_\_\_  
 SS# \_\_\_\_\_  
 Patient Name \_\_\_\_\_  
                     Last Name           First Name           M. I.  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married    Widowed    Single    Minor  
 Separated    Divorced  
 Occupation \_\_\_\_\_  
 Patient Employer/School \_\_\_\_\_  
 Employer/School Address \_\_\_\_\_  
 \_\_\_\_\_  
 Employer/School Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_  
 SS# \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 \_\_\_\_\_

**INSURANCE**

Who is responsible for this account? \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Id# \_\_\_\_\_ Group# \_\_\_\_\_  
 Is patient covered by additional insurance?  Yes  No  
 Subscriber's Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Id# \_\_\_\_\_ Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_, and assign directly to Dr. Johnathan Oakley all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative  
 \_\_\_\_\_  
 Print name of Patient, Parent, Guardian or Personal Representative  
 \_\_\_\_\_  
 Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**PHONE NUMBERS**

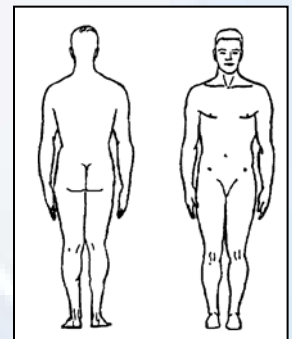
Home Phone ( ) \_\_\_\_\_  
 Cell Phone ( ) \_\_\_\_\_  
 Best time and place to reach you \_\_\_\_\_  
 IN CASE OF EMERGENCY, CONTACT  
 Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Home Phone \_\_\_\_\_

**ACCIDENT INFORMATION**

Is condition due to an accident?  Yes  No  
 Date \_\_\_\_\_  
 Type of accident  Auto  Work  Home  Other  
 To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other  
 Attorney Name (if applicable) \_\_\_\_\_

**PATIENT CONDITION**

Reason for Visit \_\_\_\_\_  
 When did your symptoms appear? \_\_\_\_\_  
 Is this condition getting progressively worse?  Yes  No  Unknown  
 Mark an X on the picture where you continue to have pain, numbness, or tingling.  
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe 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? \_\_\_\_\_  
 Does it interfere with your  Work  Sleep  Daily Routine  Recreation  
 Activities or movements that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down



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 \_\_\_\_\_

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

**EXERCISE**

- None
- Moderate
- Daily
- Heavy

**WORK ACTIVITY**

- Sitting
- Standing
- Light Labor
- Heavy Labor

**HABITS**

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs \_\_\_\_\_  
 Drinks/Week \_\_\_\_\_  
 Cups/Day \_\_\_\_\_  
 Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____