

2. Health Insurance / Self Pay

Insurance Information:

Health Ins. Name: _____ ID # _____

Group # _____ Insurance Phone # _____

When did your pain begin and how? _____

What are your current complaints?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Fever/Infection | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Ringing/Pain in ears | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Disc Hernia |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Pins and Needles _____ |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Thigh Pain | <input type="checkbox"/> Urinary/Bowel difficulty | <input type="checkbox"/> Numbness _____ |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Tingling _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Muscle Ache |
| <input type="checkbox"/> Rib Pain | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Constant Irritability | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Forearm Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Tennis Elbow |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Other _____ | | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient or Parent/Guardian of Minor

Today's Date