



RAPP CHIROPRACTIC

Patient Information

Date
Patient Name
Address
City
State
Sex
Occupation
Employer
Home Phone
Cell Phone
Work Phone
Email
How did you hear about us?

IN CASE OF EMERGENCY, CONTACT

Name
Relationship
Phone

Insurance

Primary Insurance Co.
Secondary Insurance Co.
Auto Claim #
Policyholder
Policyholder's Date of Birth
Guarantor
Relationship to Patient

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

Name of Insurance Company(ies)
and assign directly to Rapp Chiropractic 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 payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

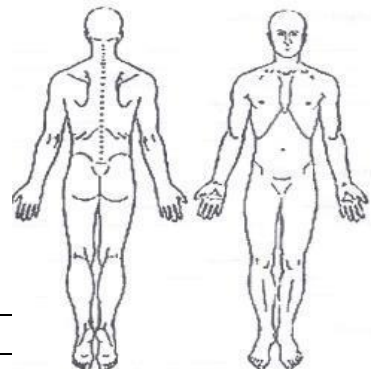
Signature of Patient, Guardian or Personal Representative
Print name of Patient, Guardian or Personal Representative
Date
Relationship to Patient

Patient Condition

Reason for Visit
When did your symptoms start?
Are your symptoms getting progressively worse?
Rate the severity of your pain (average) on a scale from 0 (no pain) to 10 (severe pain)
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Please list all current medications, supplements, past traumas and surgeries:

If none, please write none

Medications/ Supplements:
Surgeries and appx. dates:
Past Traumas:



## General Medical Information

For each of the conditions, please mark the Past/Present column as it pertains to your health history of medical condition. For any of the questions that you placed a check mark next to, please explain in the comment field (below) as clearly as possible.

What is your height? \_\_\_\_\_ ft. \_\_\_\_\_ in.      What is your weight? \_\_\_\_\_ lbs.

Do you exercise regularly?  Yes  No

If yes, how often? \_\_\_\_\_

Past	Present	Past	Present	Past	Present			
<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alc. Dependency
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Skin Rash
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Communicable Disease
<input type="checkbox"/>	<input type="checkbox"/>	Knee Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Any Childhood Disease
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Bone Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pelvic Pain
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Testicular Lumps
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Urination
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction

Indicate if an immediate family member has had any of the following (parents, siblings, grandparents, aunts, uncles):

Rheumatoid Arthritis    Heart Problems    Diabetes    Cancer    High Blood Pressure

Other:

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**Other Comments or Concerns:**

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