ASPEN CHIROPRACTIC

DR. JASON LEE

1 PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name *Middle Initial*

Sex ☐ M ☐ F Age _____

Date of Birth _____

Social Security _____

Occupation _____

☐ Married ☐ Single ☐ Minor

Address _____

City _____

State _____ Zip _____

E-mail _____

Spouse/Contact Name _____

Whom may we thank for referring you? _____

_____

2 INSURANCE INFORMATION

Insurance Co. _____

Group # _____

Policy # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I authorize Aspen Chiropractic and Dr. Jason Lee to release or obtain my medical information to insurance, attorney, or claim adjusters as may be necessary in the treatment and payment of my care.

I assign directly to Dr. Jason Lee insurance benefits for treament rendered.

_____
Signature of Patient/Guardian

_____
Date

3 PHONE NUMBERS

Cell Phone (_____) _____

Home Phone (_____) _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Phone (_____) _____

4 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

continued on back →

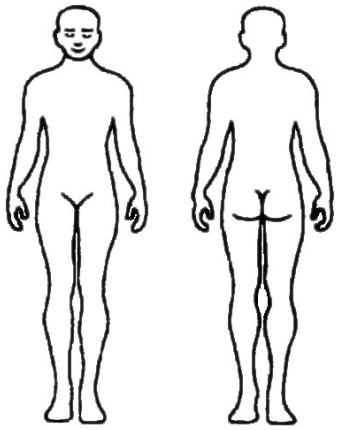
5 PATIENT CONDITION

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 of 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Sweilling ☐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

6 HEALTH HISTORY

What treatment have you already received for your condition?
☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic

Date of Last: Physical Exam _____ Spinal X-Ray_____ Massage _____

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

AIDS	☐Yes	☐No	Diabetes	☐Yes	☐No	Migraine	☐Yes	☐No
Anemia	☐Yes	☐No	Headaches	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Arthritis	☐Yes	☐No	Heart Disease	☐Yes	☐No	Pinched Nerve	☐Yes	☐No
Asthma	☐Yes	☐No	Herniated Disc	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Cancer	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Stroke	☐Yes	☐No
Depression	☐Yes	☐No	High Cholesterol	☐Yes	☐No			

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 _____

Are you pregnant? ☐Yes ☐No Due Date _____

Injuries/Surgeries you have had	Description	Date
	_____	_____
	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7 INFORMED FINANCIAL AND CONSENT POLICY

All payments are due at time of service, unles special arrangements have been agreed prior to the visit. The patient is responsible for all treatment rendered that are denied or not paid in full by insurance. As a courtesy to our patients, we will bill your insurance for you. I understand I am responsible for a $15 fee for failure to keep any scheduled appointment.

I consent to all necessary examination procedures, x-rays, or treatments prescribed by my chiropractor or his assistants, as is needed.

_____ _____
Signature of Patient/Guardian *Date*