Rossow Chiropractic Clinic
William N. Rossow, D.C.
Daniel C. Roebuck, D.C.

Patient Information

Date:

Patient Name:

Address:

City: State: Zip:

Sex: M F Age: Birthdate:

Please Select:

Single Married Separated Divorced Widowed

Number of Children:

Patient SS#:

Occupation:

Employer:

Whom may we thank for referring you?

CONTACT INFO

Cell:

Home:

Work: Ext:

Email:

*Email will not be shared with any other entity under penalty of Federal Law

**Prefered Method of Contact:*

Call Home Call Cell Text Email

Spouse's Name:

Spouse's Occupation:

Patient Condition

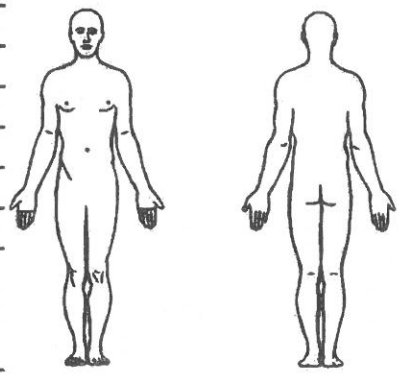
Reason for visit?

When did your symptoms appear?

If long standing, when did THIS episode begin?

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 0 (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 consistant? 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 LAYING DOWN*

INSURANCE

Subscriber's Name: Subscriber's Birthdate:

Record Release

To whom may we release, discuss or inform of your condition:

Assignment and Release

I, the undersigned certify that I (or my dependent(s)) have insurance coverage and assign directly to Rossow Chiropractic all insurance benefits, if any, insurance, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____

Relationship:_____ Date:_____

Health History

What treatment have you already received for your condition? ***Medications*** ***Surgery*** ***Physical Therapy***
Chiropractic Services ***None*** ***Other:*** _____

Name of the doctor(s) who have treated you for your condition: _____
Have you been told you may need surgery? ***Yes*** ***No***
By whom?

What made you finally decide to seek treatment for this condition? (just won't go away, pain, interference with work,family duties, recreation, etc.) _____

What made you decide to see a Doctor of Chiropractic? (Referred by your physician,want to avoid side-effects of medicine,want to avoid surgery,want to treat naturally if possible,etc.) _____

Family Doctor:

A report will be sent to your treating or referring physician(s) to keep them informed of your treament and progress with your authorization.

Please Initial: ____ Please provide a report to my physicians ____ Please do **NOT** provide a report to my physicians

Date of Last:		Spinal X-Ray		MRI, CT-Scan,Bone Scan	
Physical Exam		Chest X-Ray			
Spinal Exam		Blood Test			
Dental X-Ray		Urine Test			

Please Circle any conditions below if you now have, or have had in the past

AIDS/HIV	Emphysema	Miscarriage	Scarlet Fever
Alcoholism	Epilepsy	Mononucleosis	Stroke
Allergy Shots	Fractures	Multiple Sclerosis	Suicide Attempt
Anemia	Glaucoma	Mumps	Thyroid Problems
Anorexia	Goiter	Osteoporosis	Tonsilitis
Appendicitis	Gonorrhea	Pacemaker	Tuberculosis
Arthritis	Gout	Parkinson's	Tumors, Growths
Asthma	Heart Disease	Pinched Nerve	Typhoid
Bleeding Disorders	Hepatitis	Pneumonia	Ulcers
Breast Lump	Hernia	Polio	Vaginal Infections
Bronchitis	Herniated Disk	Prostate Problems	Venereal Disease
Bulimia	Herpes	Prosthesis	Whooping Cough
Cancer	High Blood Pressure	Psychiatric Care	Other: _____
Cataracts	High Colesterol	Rheumatoid Arthritis	_____
Chemical Dependancy	Kidney Disease	Rheumatic Fever	_____
Chicken Pox	Liver Disease		
Diabetes	Measles		
	Migraines		
	Headaches		

Exercise		***Work Activity***		***Habits/Other***			
_____	None	_____	Sitting	____	Smoking	Packs/Day	_____
_____	Moderate	_____	Standing	____	Alcohol	Drinks/Week	_____
_____	Daily	_____	Light Labor	____	Coffee/Caffine	Cups/Day	_____
_____	Heavy		Heavy Labor		High Stress Level	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***