Brownsburg Chiropractic Ctr * Dr. G. Lyman Shaw * 17 Boulevard Motif * Brownsburg, Indiana 46112
(317) 852-3870 (O) (317) 852-7417 (F)

GENERAL INFORMATION

NAME_____TODAYS DATE_____AGE_____

BIRTH DATE_____SEX ☐ M ☐ F MARRITAL STATUS ☐ S ☐ M ☐ W ☐ D

ADDRESS_____CITY _____STATE _____

ZIP_____HOME PHONE_____ WORK PHONE_____ EXTENSION _____

CELL/BEEPER_____ E-MAIL_____(NEWS LETTER ONLY)

SS#_____ DRIVERS LICENSE#_____ EMPLOYER_____

OCCUPATION_____SPOUSE'S NAME_____

SPOUSE'S EMPLOYER_____SPOUSE SS#_____

MED. INS. HOLDER (INSURED)_____INSURED SS#_____

REFERRAL NAME_____ FRIEND / RELATIVE **(circle one)**

☐ YELLOWBOOK ☐ AT&T REAL YELLOWPAGES ☐WEB ☐ GIFT CERTIFICATE/COUPON ☐ OTHER SOURCE

MEDICAL INFORMATION

FAMILY DOCTOR_____LAST SEEN_____

PREVIOUS CHIROPRACTOR_____LAST SEEN_____

MEDICATIONS_____LAST X-RAY_____

DR's SEEN FOR THIS PROBLEM_____

OPERATIONS AND PROCEDURES

DATE	DATE	DATE
_____VACCINATIONS	_____TUBES IN EARS	_____SINUS
_____TONSILECTOMY	_____APPENDECTOMY	_____HERNIA
_____GALL BLADDER	_____FEMALE ORGANS	_____THYROID
_____BACK OPERATION	_____RECTAL SURGERY	_____STOMACH

OTHER:_____

☐ **I HAVE NEVER HAD ANY OPERATIONS / SURGERIES**

ALLERGIES

☐ IBUPROFEN ☐ ASPIRIN ☐ TYLENOL ☐ ADHESIVES ☐SULFA DRUGS
☐ OTHER MEDICATIONS / SUBSTANCES_____

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HABITS

□ SMOKING _____ PACKS/DAY □ DRINKING _____DRINKS/DAY □ COFFEE _____CUPS/DAY

EXERCISE

□ NONE □ MODERATE □ DAILY TYPE: _____

FAMILY HISTORY

	DIABETES	HEART	CANCER	KIDNEY	BACK
MOTHER	□	□	□	□	□
FATHER	□	□	□	□	□
BROTHER	□	□	□	□	□
SISTER	□	□	□	□	□

CURRENT HISTORY

ARE YOUR PRESENT INJURIES DUE TO AN □ INJURY □ ON THE JOB □ AUTO ACCIDENT

□ OTHER_____

ARE YOU NOW OR HAVE YOU EVER BEEN DISABLED (SERVICE OR WORK)? □ YES □ NO

LIST ANY ACCIDENTS / FALLS AND DATES □CAR_____ □SPORTS_____
□ SCHOOL_____ □ OTHER_____
LIST ANY BROKEN BONES OR DISLOCATIONS: _____
DATE EVER ON CRUTCHES: _____ WHY: _____
DATE OF SPINAL TAPS OR INJECTIONS: _____
DATE X-RAYS LAST TAKEN: _____ WHY: _____
ALL PERSCRIPTION DRUGS PRESENTLY TAKING: _____
OVER THE COUNTER MEDICATION: _____
DO YOU SUFFER WITH ANY OTHER CONDITIONS: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?

□ 541 APPENDICITIS	□ 280 ANEMIA	□ 429.9 HEART DISEASE	□ 716 ARTHRITIS
□ 480 PNEUMONIA	□ 055 MEASLES	□ 487 INFLUENZA	□ 345 EPILEPSY
□ 390 RHEUMATIC FEVER	□ 072 MUMPS	□ 511 PLEURISY	□ 240 GOITER
□ 045 POLIO	□ 052 CHICKEN POX	□ 305.0 ALCOHOLISM	□ 724.2 LUMBAGO
□ 011 TUBERCULOSIS	□ 250 DIABETES	□ 099 VENEREAL DIS.	□ 690 ECZEMA
□ 033 WHOOPING COUGH	□ 239 CANCER	□ 319 MENTAL DISORDER	□ 044 HIV (+)
□ 905.3 ALLERGIES	□ 783 LOSS OF WEIGHT	□ 786.5 CHEST PAIN	□ 780.4 DIZZINESS
□ 799.2 NERVOUSNESS	□ 787.3 BELCHING OR GAS	□ 780.6 FATIGUE	□ 780.3 CONVULSIONS
□ 780.52 LOSS OF SLEEP		□ 780.2 FAINTING	□ 491 BRONCHITIS

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Fill in the regions on the diagram with letters representing your symptoms

N…numbness

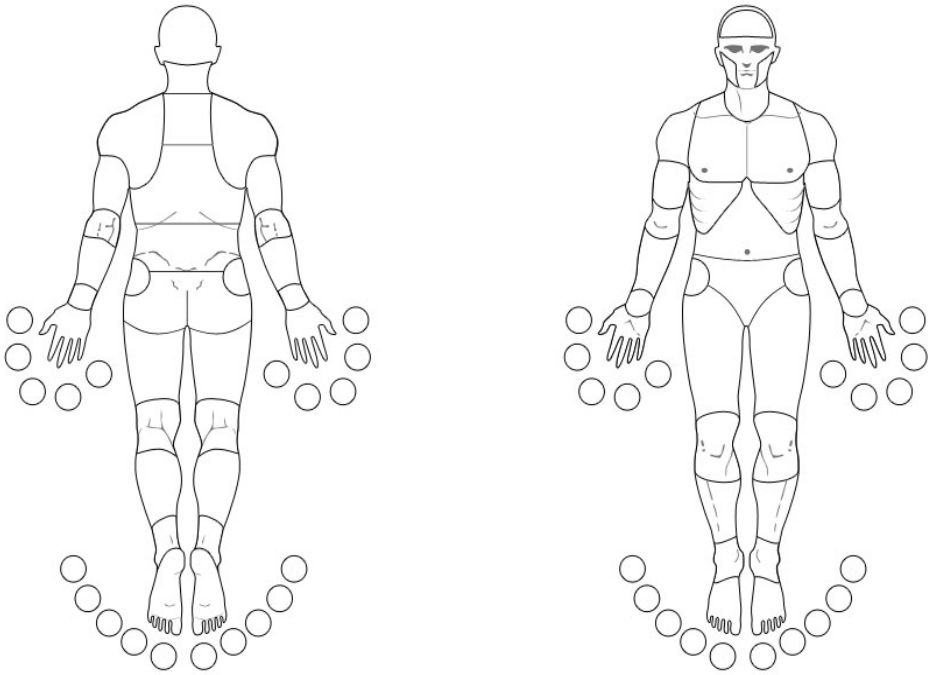
T …tingling

S…soreness

P…pain

A…ache

ST…stiffness



Consent of Professional Services and Release of Information

I hereby authorize and release the Doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that he/she deems it necessary in my case. I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation, which is or may be liable under a contract to this office, or to the patient, or to a family member, or to a employer of the patient, for all or part of the clinics charge, including but not limited to hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I, the undersigned, acknowledge that the above information is accurate and complete. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I agree that I am personally responsible for payment of all unpaid bills. I agree to pay a finance charge of 1.5% per month, or an annual rate of 18%, applied to any unpaid balance greater than 60 days maturity. I also agree to pay reasonable attorney fees and other fees that arise out of collection procedures amounting to 40% of unpaid balance, for any and all unpaid balances.
I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Parent/Guardians Signature: _____

Patient's/Guardian's Signature: _____Date: _____