Reilly Chiropractic

777 Main St. Milford, OH 45150

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that as a patient of Reilly Chiropractic, Inc. I am authorizing them to proceed with any treatment that they deem necessary.

Acknowledgement:

I authorize Reilly Chiropractic Physicians to release any medical information necessary to bill my account to my insurance company or its authorized representative, Workers Compensation or attorney. I authorize payment of my medical benefits directly to Reilly Chiropractic Physicians. I understand that I am financially responsible for charges not covered by this authorization.

Women Only:

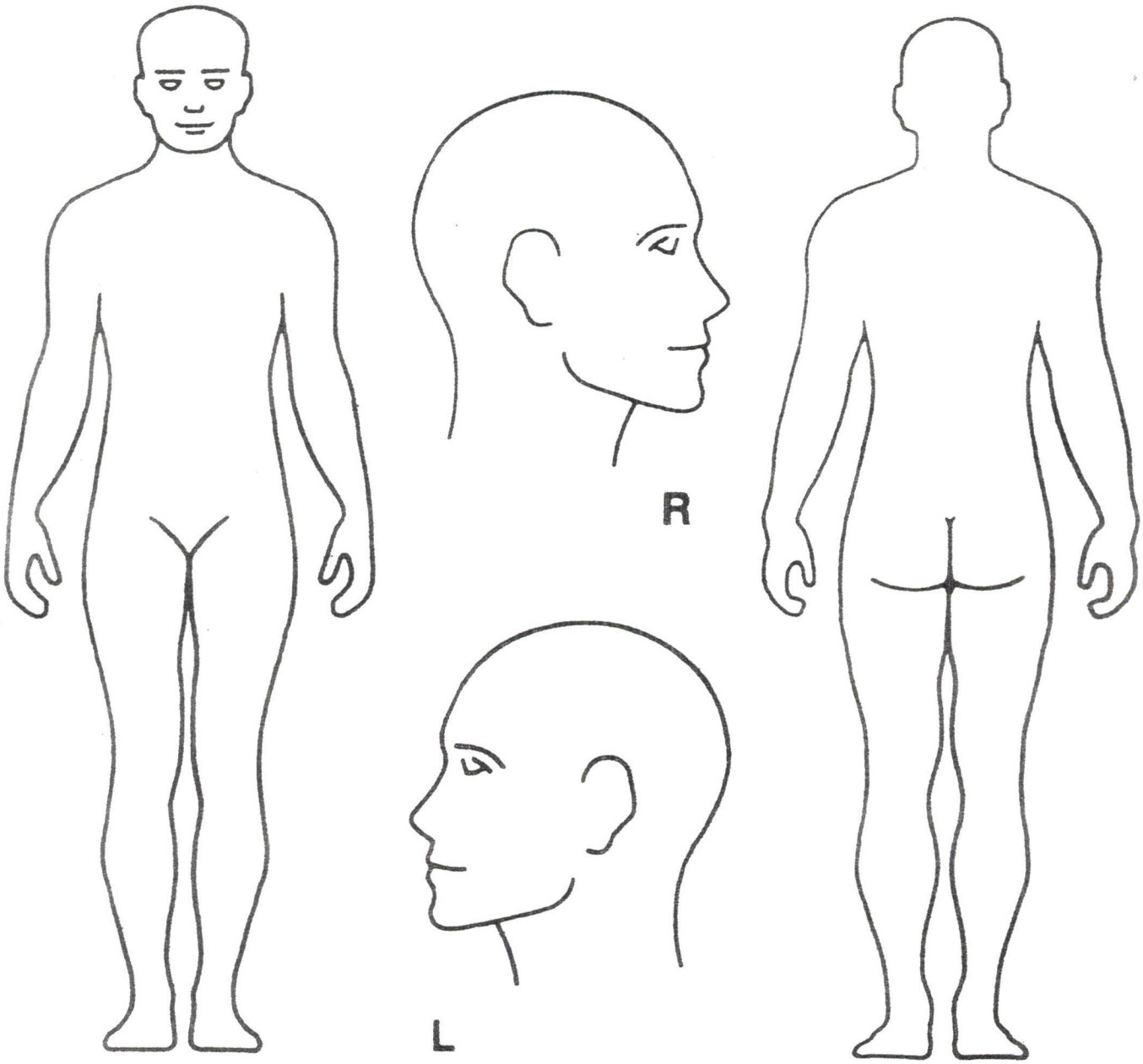
To the best of my knowledge I am / am NOT pregnant anf (give my permission / don't give my permission) to x-ray me for diagnostic interpretation.
(circle one above) (circle one above)

_____ _____

Signature: Date:

NAME _____ DATE _____

PLEASE MARK AREA(S) OF PAIN OR INJURY ON THE ILLUSTRATION BELOW AND GIVE A WORD DESCRIPTION OF THE SYMPTOMS YOU ARE HAVING IN THOSE AREAS



Other Comments _____