# Welcome to Sunrise!

## Patient Information

NAME _____ DATE _____

GENDER _____ AGE _____ BIRTH DATE _____ SOCIAL SECURITY _____

MARITAL STATUS _____ [ ] NUMBER AND AGES OF CHILDREN _____

OCCUPATION _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE NUMBER _____

## Contact Information

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CHECK THE BEST NUMBER TO REACH YOU AT

☐ HOME PHONE NUMBER _____

☐ CELL PHONE NUMBER _____

☐ WORK PHONE NUMBER _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____

RELATIONSHIP _____ BEST CONTACT NUMBER _____

## Accident Information

IS YOUR CONDITION DUE TO AN ACCIDENT? YES NO

IF YOU ANSWERED YES TO THE ABOVE QUESTION, PLEASE PROVIDE THE FOLLOWING INFORMATION:

TYPE OF ACCIDENT _____

WHO IS HANDLING THE ACCIDENT CLAIM FOR YOU? _____

CONTACT _____ PHONE NUMBER _____

ACCIDENT CLAIM NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

## Insurance Information

PRIMARY INSURANCE CARRIER _____ POLICY NUMBER _____

WHO IS THE HOLDER OF THE POLICY? (CIRCLE ONE)

SELF SPOUSE PARENT OTHER _____

IF THE HOLDER IS SOMEONE OTHER THAN SELF, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME _____

GENDER _____ BIRTH DATE _____ SOCIAL SECURITY _____

IS THE INSURANCE THROUGH THE EMPLOYER OF THE POLICY HOLDER? YES NO

### ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO CHRISTY GARDE, D.C. 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 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 _____ DATE _____

## Additional Insurance Information

PLEASE USE THIS AREA TO LIST ANY ADDITIONAL INSURANCE POLICIES OR SUPPLEMENTS.

INSURANCE CARRIER _____ POLICY NUMBER _____

POLICY HOLDER _____ RELATIONSHIP _____

INSURANCE CARRIER _____ POLICY NUMBER _____

POLICY HOLDER _____ RELATIONSHIP _____

## Insurance Benefits

DOES YOUR INSURANCE COVER CHIROPRACTIC VISITS?

YES NO UNKNOWN

DO YOU HAVE AN OUT OF POCKET CHARGE WHEN VISITING A CHIROPRACTOR?

- ◯ NO. I HAVE FULL COVERAGE
- ◯ YES, I'M PAYING ON MY DEDUCTABLE
- ◯ YES, I HAVE A COPAYMENT OF _____
- ◯ I DON'T KNOW

# Health Report

REASON FOR VISIT: _____

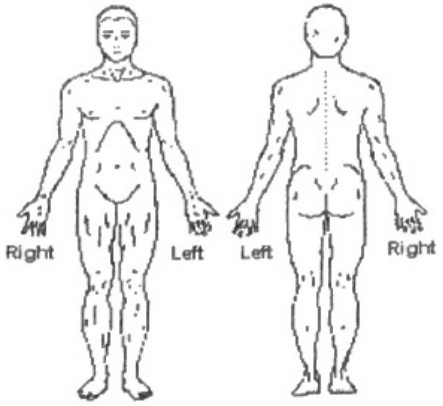
WHEN DID YOUR SYMPTOMS APPEAR? _____

IS YOUR CONDITION GETTING WORSE? YES NO UNKNOWN

PLEASE CIRCLE THE DEGREE OF YOUR PAIN
[LOW] 0 1 2 3 4 5 6 7 8 9 10 [HIGH]

USING THE SYMBOLS ON THE RIGHT, MARK ON THE DIAGRAM WHERE YOU FEEL PAIN.

| | |
|---|---|
| NUMBNESS | = = = |
| DULL ACHE | O O O |
| BURNING | X X X |
| SHARP/STABBING | / / / |
| PINS & NEEDLES | + + + |
| OTHER _____ | ^ ^ ^ |




## Muscles & Joints

___ LOW BACK PROBLEMS
___ PAIN BETWEEN SHOULDERS
___ NECK PROBLEMS
___ ARM PROBLEMS
___ LEG PROBLEMS
___ BROKEN BONES

## General Symptoms

___ ASTHMA
___ CHRONIC COUGH
___ DEPRESSION
___ DIZZINESS
___ FAINTING
___ HEADACHE
___ NERVOUSNESS
___ NUMBNESS
___ OTHER _____

## Cardio-Vascular

___ HIGH BLOOD PRESSURE
___ HEART ATTACK
___ POOR CIRCULATION
___ HEART TROUBLE
___ STROKES

## Gastro-Intestinal

___ COLON PROBLEMS
___ CONSTIPATION
___ DIARRHEA
___ EXCESSIVE THIRST
___ GALLBLADDER TROUBLE
___ HEMORRHOIDS
___ LIVER/GALLBLADDER
___ NAUSEA
___ ABDOMINAL PAIN
___ ULCER
___ POOR DIGESTION

## Ear/Nose/Throat

___ EARACHE
___ NOSE BLEEDS
___ SORE THROATS

## Genito-Urinary

___ FREQUENT URINATION
___ PROSTATE PROBLEMS
___ LOSS OF BLADDER CONTROL

## Skin or Allergies

___ BOILS
___ BRUISING EASILY
___ ECZEMA, RASH OR DERMATITIS
___ HIVES
___ ALLERGY _____

## For Women Only

___ BIRTH CONTROL _____
___ HORMONE REPLACEMENT
___ HOT FLASHES
___ IRREGULAR CYCLE
___ MISCARRIAGE
___ PAINFUL PERIODS
___ VAGINAL DISCHARGE
___ BREAST PAIN
___ PREGNANT NOW? YES NO

## Other Conditions

_____
_____
_____
_____

| EXERCISE | WORK ACTIVITY | INJURIES | SURGERIES |
|---|---|---|---|
| How often do you exercise and what type(s) do you perform? | What physical activities are prominent at your job? | Please list any injuries and when they occurred. | Please list any surgeries and when they occurred. |

| VITAMINS/HERBS/MINERALS | MEDICATIONS | HABITS | ALLERGIES |
|---|---|---|---|
| Please list any supplements you are currently taking. | Please list any medicines you take regularly. | Please answer these questions regarding your lifestyle.<br>SMOKING: ____ PACKS A DAY<br>ALCOHOL: ____ DRINKS A WEEK<br>CAFFEINE: ____ CUPS A DAY<br>OTHER _____ | Please list any allergies you suffer from. |

I HEREBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH. I AGREE TO ALLOW CHRISTY GARDE, D.C. TO EXAMINE ME FOR FURTHER EVALUATION.

_____ _____

PATIENT SIGNATURE DATE

Recycle