WELCOME TO INFINITY SPINE CENTER

Last Name: _____ First Name: _____ M.I.: ____
What name do you prefer to go by? _____
Address: _____ APT #: _____
City: _____ State: _____ Zip Code: _____
Email (for office use only): _____
Home Phone: (_____) _____ Work Phone: (_____) _____EXT_____
Cell Phone: (_____) _____ Fax Line: (_____) _____
Date of Birth: ____/____/____ Sex: M F SSN: _____ Height _____ Weight _____
Spouse's name: _____ _____ Phone: (_____) _____
Emergency contact other than Spouse:
Name: _____ Relation: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
How did you hear about us/whom may we thank for referring you? _____

Have you had an accident (major or minor) within the past 2 years? NO YES
If yes, what type of accident? AUTO WORK OTHER: _____
If yes, what date and time did this accident occur? ____/____/____ _____:_____ am pm
If you are seeking care due to an accident it is possible care may be provided at no out of pocket cost to you. If seeking care due to an injury please ask the front desk for the "accident questionnaire" at the time.
Are you seeking care due to an auto or work injury? NO YES Initial Here: _____

Do you have primary health insurance policy? NO YES
Do you have a secondary health insurance policy? NO YES
If yes, please provide the front desk with your health insurance card(s) at this time and our office will inform you of your coverage. ***Most insurance companies cover our services.***
Policy Holder's Name: _____ Date of Birth: ____/____/____ SSN: _____
Relation to Policy Holder: SELF SPOUSE CHILD OTHER: _____
Your Marital Status: S M D W Legally Separated
Your Student Status: Full-time Part-time Non-student
Your employment status: Full-time Part-time Retired
Your Employer: _____ Spouse's employer, if married: _____
I realize my health insurance company will be billed as a service to me. Until my benefits can be verified, I will be responsible for payment of care today. If I have coverage, the amount I pay will be applied to my deductible and/or my daily co-insurance payments. If I do not have coverage the doctor will discuss an affordable plan with me. I may also be asked to help pursue the insurance company in small claims court if necessary. Initial Here: _____

There is no fee for consulting with the doctor. Fees begin when a spinal or spine related problem is found and you decide you want us to take care of it for you. The initial visit will include a history, extended examination, and x-rays. Day two will consist of a report of findings and your initial correctiond with Dr. John P. Thoma, D.C. If you are here due to an accident, the regular fees for today's visit will be paid in full by auto or worker's compensation insurance. **If your claim is denied, we will ask you to pay for today's visit.**

_____ _____ ____/____/____
Signature of Patient/Guardian **Print Name** **Date**

HEALTH HISTORY QUESTIONNAIRE

PATIENT'S FULL NAME: _____

Are you pregnant? N/A (male) No Unsure Yes, Due Date: ____/____/____
Have you had x-rays within the last year? NO YES If Yes, date: ____/____/____
Reason: _____
Doctor's name & phone where x-rays were taken: _____
List any medications (including birth control) or vitamins you are currently taking:
_____
_____
List Allergies: _____
List Fractured Bones: _____
_____
List Surgeries or Transplants: _____
_____
List major/minor accidents trauma: _____
_____
Do you have any concerns about chiropractic care? NO YES, _____
Do you have any concerns about therapy/rehabilitation? NO YES, _____

Check all that apply:

Headaches	Osteoporosis	Hearing Problems	*Ringing in Ears*	Depression
Neck Pain	Sore Throats	Aortic Aneurysm	Vision Problems	*Dizziness*
Shoulder Pain	Nervousness	Heart Disease	Low Blood Pressure	Trauma
Upper Back Pain	Seizures	Kidney Problems	High Blood Pressure	Cold
Mid-Back Pain	Loss of Energy	Cancer/tumor	Digestive Trouble	Diarrhea
Low Back Pain	Constipation	Gall Bladder Issues	Asthma/Weak lungs	HIV/AIDS
Hip Pain	Cramps	Prostate Issues	Urinary Tract Infections	Diabetes
Leg Pain/Cramps	Arthritis/rheumatism	Difficulty Sleeping	Stroke: date: ___/___/___	Tonsillitis

Back/Spinal Condition, please describe disorder: _____
Abnormal weight gain/loss Other: _____

Family Medical History: Please check all the apply

Cancer	Stroke	Seizures	Diabetes	Abnormal Blood Pressure
Osteoporosis	Cardiovascular Disease			

Current Chief Complaint:
Are you here for: a check up a specific problem: _____
What were you doing when this complaint first appeared: _____
What date did your chief complaint begin? ____/____/____

HEALTH HISTORY QUESTIONNAIRE
CONT'ed

Have you had this complaint before? NO YES, _____
Where specifically is your complaint located? _____
Is you complaint: Constant Comes and Goes Other: _____
What activities make your complaint better? _____
What activities make your complaint worse? _____
What position relieves this complaint? _____
How often is your complaint present (please circle)? 0-25% 26-50% 51-75% 76-100%
Does this complaint interfere with work/living habits? NO YES, _____
What have you done for this complaint? _____

Check each box that describes the chief complaint you discussed above:

Dull Pain	Sharp Pain	Numbness	Tingling	Stiff	Throbbing	Aching
Shooting	Burning	Cramping	Swelling	Redness	Radiating: From: ____ to _____	

Please circle your pain level on this scale: **0 = no pain…up to…10 =intolerable pain**

0 1 2 3 4 5 6 7 8 9 10

My complaint is:
Better in the: AM MIDDAY PM Never Lessons
Worse in the: AM MIDDAY PM Constant
Does your complaint interfere with your sleep? NO YES

Have you consulted/received other treatments for your chief complaint? NO YES
If yes, what treatments: _____
_____
Result of treatments: _____
_____
Name/ Phone number of treating doctor: _____
Treating doctor's specialty: _____

Are there any other problems/pains that you wish to address during this visit? NO YES
_____
_____

By signing below, I hereby certify the above information is complete and accurate to the best of my knowledge. Inaccurate information could be dangerous to my health.

_____ _____ ____/____/____
Signature of Patient/Guardian Print Name Date