



Confidential Patient Information

Michael T. Owsley, DC
585-B Westport Rd
Elizabethtown, KY 42701

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. Thank you.

Date ___/___/___		Name _____		SS# _____-_____-_____	
Home Phone _____		Cell Phone _____		Email _____	
Address _____			City _____		State ___ Zip _____
Age _____	Birth Date ___/___/___		Marital Status S M W D		Sex M F
Number of Children _____			Ages _____		
Occupation _____		Employer _____		Shift 1 2 3	
Work Phone _____		Work Address _____		Years _____	
Name of Spouse/Guardian _____			Spouse's Work Phone _____		
Spouse's Occupation _____			Spouse's Employer _____		
How did you hear about our office? _____			Have you ever seen a Chiropractor? Yes No		
Have you ever treated with Dr. Owsley before Y N If so, when? _____					

Are your present problems due to an injury? Yes No On the Job Auto Collision Personal Injury Other

Have you made a report of your accident? Yes No To employer Auto Carrier Other _____

Are you now or have you ever been disabled/impaired? (Service or Work?) Yes No When _____

Have you retained an attorney? Yes No Name & Address _____

CHIEF COMPLAINT/REGIONS OF PAIN

- 1) _____
- 2) _____
- 3) _____
- 4) _____

HABITS

Smoking Packs/Day _____

Alcohol Drinks/Day _____

Coffee Cups/Day _____

Soda Cups/Day _____

EXERCISE

None

Moderate

Daily

Type _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> 303.9 Alcoholism	<input type="checkbox"/> 345. Epilepsy	<input type="checkbox"/> 072. Mumps
<input type="checkbox"/> 280. Anemia	<input type="checkbox"/> 240. Goiter	<input type="checkbox"/> 511. Pleurisy
<input type="checkbox"/> 541. Appendicitis	<input type="checkbox"/> 429.9 Heart Disease	<input type="checkbox"/> 480. Pneumonia
<input type="checkbox"/> 716. Arthritis	<input type="checkbox"/> 042. HIV Positive	<input type="checkbox"/> 045. Polio
<input type="checkbox"/> 239. Cancer	<input type="checkbox"/> 487. Influenza	<input type="checkbox"/> 390. Rheumatic Fever
<input type="checkbox"/> 052. Chicken Pox	<input type="checkbox"/> 724.2 Low Back Pain	<input type="checkbox"/> 737.30 Scoliosis
<input type="checkbox"/> 250. Diabetes	<input type="checkbox"/> 055. Measles	<input type="checkbox"/> 846. Sprain/Strain Sacroiliac
<input type="checkbox"/> 690. Eczema	<input type="checkbox"/> 319. Mental Disorder	<input type="checkbox"/> 847.0 Whiplash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MARK PAIN REGION

Please mark your areas of pain on the figures below.

SEVERITY OF PAIN

List region of pain and circle severity number (1=least, 10=greatest)

	Burning - Stabbing - Sharp - Constant ex. Neck _____ <i>sharp</i> 1 2 3 4 5 6 7 8 9 10	
	Neck _____ 1 2 3 4 5 6 7 8 9 10	
	Mid Back _____ 1 2 3 4 5 6 7 8 9 10	
	Low Back _____ 1 2 3 4 5 6 7 8 9 10	
	Hips _____ 1 2 3 4 5 6 7 8 9 10	
	Arms _____ 1 2 3 4 5 6 7 8 9 10	
	Legs _____ 1 2 3 4 5 6 7 8 9 10	

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother — Living <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father — Living <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To your knowledge, has anyone in your family ever had same/similar complaints to your current problem? Who? _____

General Health History

Please circle any current conditions and place a check mark next to any conditions which you may have experienced in the past. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

Table with columns: GENERAL SYMPTOMS, GASTRO-INTESTINAL, EYE/EAR/NOSE/THROAT, RESPIRATORY, GENITO-URINARY. Lists various medical conditions with associated codes.

Table with columns: MUSCLES & JOINTS, CARDIO-VASCULAR, SKIN OR ALLERGIES, FOR WOMEN ONLY. Lists various medical conditions with associated codes.

What surgeries have you had? _____

List Broken Bones _____

Have you ever been on crutches? Yes No Why? _____

Have you ever had a lapse of memory? Yes No Have you ever been unconscious? Yes No

List any accidents or falls/list dates: Car _____ Sports _____ ATV/Watercraft _____ School _____ Other _____

Do you suffer from any condition other than that for which you are now consulting us? _____

List medications and diet supplements you take _____

NOTES _____

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 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 I am an active patient in 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. Patients may obtain one free copy of their file and x-rays upon written request. Copying fees will apply to any subsequent copies provided.

Patient's Signature _____ SS# _____ - _____ - _____ Date ____/____/____

Guardian's Signature _____ SS# _____ - _____ - _____ Date ____/____/____

Other Responsible Party _____ SS# _____ - _____ - _____