ABOUT YOU

Deines Chiropractic
307-673-5075
1821 S. Sheridan Ave
Unit A
Sheridan, WY 82801

Legal Name: _____
Preferred Name: _____
Address: _____ City: _____ State: _____ ZIP _____
Cell Phone: _____ Home Phone: _____ Email: _____
Birth Date: _____ Age: _____ Gender: ○ M ○ F Significant Other: _____

Who referred you? _____ Employer: _____ Type of Work: _____

Emergency Contact: _____ Phone #: _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child
- I authorize Deines Chiropractic to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services, all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ○ Cash ○ Check ○ Credit Card

Have you been to a ○ YES chiropractor before? ○ NO
If yes, how long ago? _____

Present Complaints

1. _____ **How long has this been an issue?** _____
IS IT: ○ Dull ○ Sharp ○ Ache ○ Numb/Tingle ○ Stabbing ○ Constant ○ Occasional ○ Staying the same
○ Getting worse ○ Mild ○ Moderate ○ Severe ○ Worse in the morning ○ Worse in the evening Pain radiates to _____
2. _____ **How long has this been an issue?** _____
IS IT: ○ Dull ○ Sharp ○ Ache ○ Numb/Tingle ○ Stabbing ○ Constant ○ Occasional ○ Staying the same
○ Getting worse ○ Mild ○ Moderate ○ Severe ○ Worse in the morning ○ Worse in the evening Pain radiates to _____

***Please identify the condition(s) that brought you to this office**: Primary: _____ Secondary: _____*

*On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling a number**:*

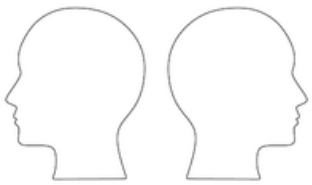
Primary or Chief complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What makes it better? _____
What makes it worse? _____
What doctors have you seen for this? _____

LIST RESRICTED ACVIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL

Are you pregnant
Or breast feeding?
○ **Yes** ○ **No**

Please mark all areas of concern



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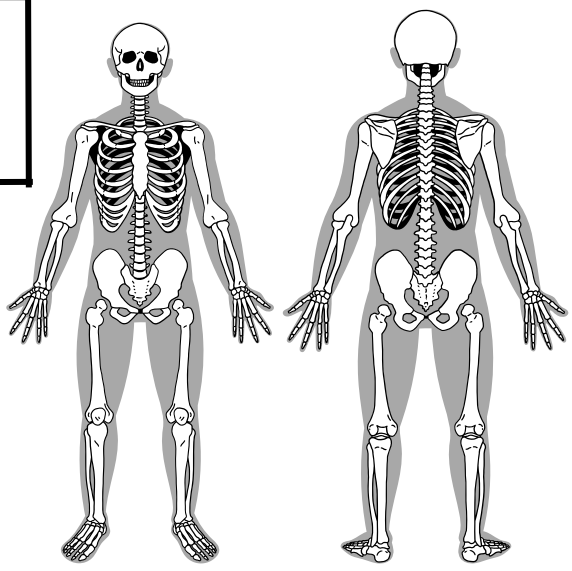

_____ _____
Patient/Parent Signature Date:

(This represents a long term authorization for all occasions of service)