Seesholtz Chiropractic

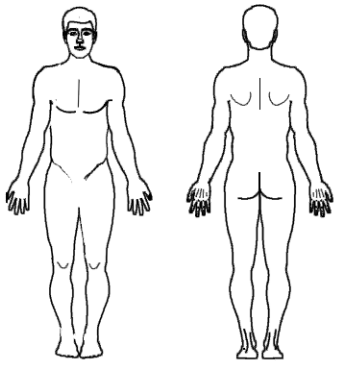
2607 Old Berwick Road
Bloomsburg, PA 17815

Phone: 570-784-2529
Fax: 866-924-2829

Email Address: _____
Cellphone: _____

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
Primary Care Physician Name: _____ PCP Phone: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain
☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began:

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date) _____
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain) _____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (explain) _____
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries _____
- ☐ Medications: _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____