Patient Registration and History:

Absolute Chiropractic Care – Lanham, LLC
9470 Annapolis Road Suite 403, Lanham, MD 20706 Tel: (301) 577-1800 Fax: (301) 577-2058 TIN: 45-4344497

Your Information

Date:_____ Sex: Male Female

Name:_____
First Last Initial

Address: _____

_____

Home #: _____ Cell #: _____

SSN #: _____ Work #: _____

Age: _____ Date of Birth: _____

Single Married Divorced Widowed

Height: _____ Weight: _____ Right __ or Left __ handed

Employer: _____

Occupation: _____

Work Address: _____

In case of emergency, please contact

Name: _____

Phone #: _____ Relationship: _____

Is your condition/visit due to an automobile accident?

YES NO

If yes, please continue with Accident Information.
If no, please skip to Insurance Information.

Your Insurance Information

Health Insurance Co.: _____

Phone #: _____ Policy #: _____

Policy Holder Name: _____

Your relationship to policyholder: _____

Automobile Accidents (complete)

Owner of the vehicle you were injured in:

Name: _____

Insurance Co.: _____

Phone #: _____ Policy #: _____

Claim #: _____ Adjuster: _____

Have you retained an attorney? YES NO

Name & Phone #: _____

Has accident been reported? YES NO

Third Party Insurance (the person that hit you):

Name: _____

Insurance Co.: _____

Phone #: _____ Policy #: _____

Claim #: _____ Adjuster: _____

Accident Information: Date of Injury:_____ Time:_____ AM PM State: ___ You braced for impact: YES NO

You were the: ___Driver ___Front Passenger ___Rear Passenger You were seatbelted: YES NO Police Report Filed: YES NO

How did the accident occur? _____

_____

Struck from: Rear Front L-side R-side Did you know you were going to be hit? YES NO Others in your car? YES NO

Approximate speed of your vehicle (or Stopped): ____mph Make/Model of your car: _____

Approximate speed of your other vehicle: ____mph Make/Model of other car: _____

Approximate damage to your car: Minimal Moderate Extensive Totaled

Did you go to the hospital? YES NO If YES, when? _____ Hospital: _____

X-Rays taken? YES NO of my: _____ How did you get to the hospital? _____

Medication prescribed: _____

Have you seen any other doctors (not including us) since the accident: YES NO If yes, who: _____

What treatment was given: _____

Medical History

Injuries/Surgeries you may have had	Description	Date(s)
Auto Accident(s)	_____	_____
Work Injuries	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM (CHECK ALL THAT APPLY)

__ Muscle disorder
__ Nervous disorder
__ Bone disorder
__ Rheumatoid Arthritis
__ Allergies
__ HIV
__ Gallbladder
__ Diabetes
__ Depression
__ Coughing blood
__ Stomach, intestines (GI)
__ Lungs, Asthma
__ Broken bones
__ Eating disorder
__ Pace maker
__ Seizures/Convulsions
__ A congenital disease
__ Excessive bleeding
__ High blood pressure
__ Low blood pressure
__ Kidney, Bladder (GU)
__ Circulatory problems
__ Osteoarthritis
__ Epilepsy
__ Alcoholism
__ Drug addiction
__ Strokes
__ Cancer
__ Ulcer
__ Hernias
__ Ears, Eyes, Nose, Throat problem
__ Tumors
__ Heart disease

Please list all medications you are currently taking: _____

_____

Are you currently under a doctor's care for anything NOT listed above: YES NO If yes, explain: _____

_____

Primary Physician Name: _____ Phone #: _____

Female Patients: Date of last menstrual cycle: _____ Are you pregnant? YES NO

Your Condition

What are your present complaints: _____

_____

When did the symptoms first appear: _____

Does if interfere with: Sleep Daily Routine Work Recreation

Activities that are painful to perform: Sitting Standing

Walking Bending Lying Down Other _____

_____

Lost time from work due to your injuries? YES NO

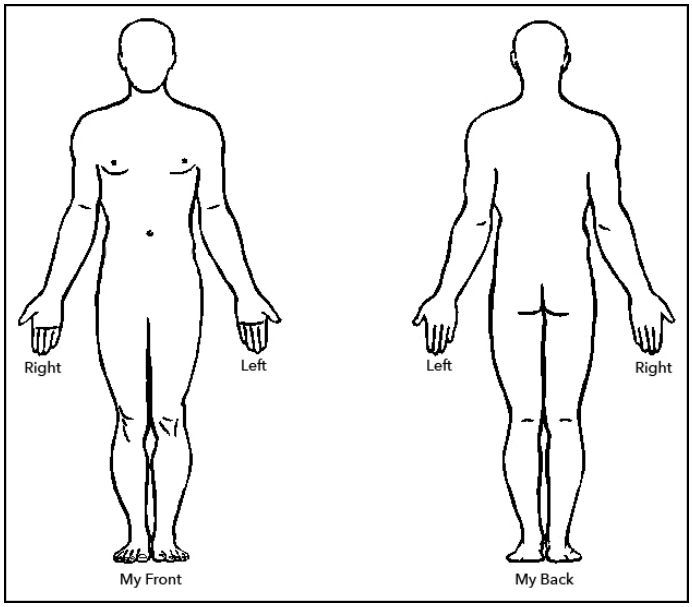
How much time lost from work? _____

Any cuts or bruises: YES NO If yes, where: _____

Since the accident my symptoms are:

Improving About the same Getting worse

PLEASE MARK AN "X" ON DRAWING TO INDICATE PAIN



Authorization for Treatment: I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid for 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 the patient is being treated at 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 preexisting medically diagnosed conditions, nor for any medical diagnosis. The patient also agrees that the statements made in this questionnaire are true and correct.

Patient/Guardian Signature: _____

X-Ray Authorization: I have been informed that x-rays may be damaging to my health. I also declare that I am NOT pregnant. I give the Doctor's office the authority to x-ray me as a diagnostic aid in evaluating my case.

Patient/Guardian Signature: _____

THANK YOU FOR TAKING TIME TO COMPLETE YOUR COMPREHENSIVE CASE HISTORY.
WE LOOK FORWARD TO WORKING WITH YOU AS A PARTNER IN YOUR EHALTH AND RECOVER.
PLEASE FEEL FREE TO ASK ANY QUESTIONS YOU MAY HAVE AT ANY TIME.