Nolz Chiropractic Clinic, PC
Dr. Jared C. Nolz
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Lisbon, IA 52253
Phone: (319) 455-2910 Fax: (319) 455-2165

Patient Information Form

Date: ____/____/____

Patient Name:_____
Last Name First Name Middle Initial

Address: _____ Sex: [ ] M [ ] F Age: _____

City: _____ State: ____ Zip: _____ Birth Date: ____/____/____ S.S.#: _____-____-_____

Cell Phone: ( ) _____-_____ Home Phone: ( ) _____-_____ Best Time to Reach You: _____

Marital Status: [ ] Married [ ] Widowed [ ] Single [ ] Divorced

In Case of Emergency, contact:

Name:_____ Relationship:_____ Phone: ( ) _____-_____

Patient Employer/School:_____ Occupation: _____

Employer/School Address: _____ Who Referred You? _____

City: _____ State: _____ Zip: _____ Employer/School Phone: ( ) ____-_____

Spouse's Name: _____ Spouse's Employer: _____

Birth Date: ____/____/____ S.S.#: _____-____-_____

Insurance Company: _____ Group #:_____ Insured Date of Birth: ____/____/____

Does patient have secondary insurance?: [ ]Yes [ ]No Subscriber's Name:_____

I certify that I, and/or my dependent(s) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Jared C Nolz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. I also give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the treatment of my condition.

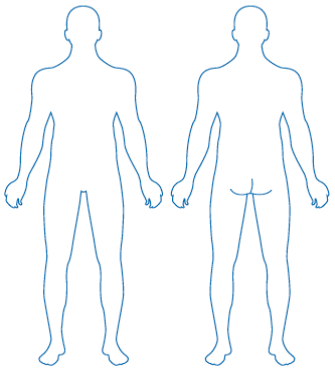
X_____ Date:____/____/____ _____
Signature of Patient (or guardian if minor) Print name of Guardian and Relationship to Patient

Is the condition due to an accident? [ ]Yes [ ]No Date: ____/____/____

To whom have reported your accident?: [ ]Auto Insurance [ ]Employer [ ]Worker Comp. [ ]Other

Type of Accident: [ ]Auto [ ]Work [ ]Home [ ]Other

Front Back



Attorney Name (if applicable): _____

Reason for Visit: _____

What caused it?: _____

When did your symptoms appear? _____

Has the condition recently been: [ ]Improved [ ]Worsened [ ]Unchanged

Please rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____.

Type of pain:
[ ]Sharp [ ]Dull [ ]Throbbing [ ]Numbness [ ]Aching
[ ]Burning [ ]Tingling [ ]Cramps [ ]Stiffness [ ]Swelling [ ]Other:_____

How often do you have this pain? [ ]Constant [ ]Frequent [ ]Occasional [ ]Intermittent

Activities or movements that are painful to perform: [ ]Sitting [ ]Standing [ ]Walking [ ]Bending [ ]Lying Down

Does it interfere with your: [ ]Work [ ]Sleep [ ]Daily Routine [ ]Recreation

What treatment have you already received for your condition?
[ ]Medications [ ]Surgery [ ]Physical Therapy [ ]Chiropractic Care [ ]None [ ]Other: _____

Name and address of other doctor(s) who have treated you: _____

Date of Last: Physical Exam: ____/____/____ Spinal X-Ray: ____/____/____ Blood Test:____/____/____
Spinal Exam: ____/____/____ Chest X-Ray: ____/____/____ Urine Test: ____/____/____
Dental X-Ray: ____/____/____ MRI, CT-Scan, Bone Scan: ____/____/____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	[ ]Yes [ ]No	Chemical Dependency	[ ]Yes [ ]No	Pinched Nerve	[ ]Yes [ ]No
Alcoholism	[ ]Yes [ ]No	Chicken Pox	[ ]Yes [ ]No	Pneumonia	[ ]Yes [ ]No
Allergy Shots	[ ]Yes [ ]No	Liver Disease	[ ]Yes [ ]No	Polio	[ ]Yes [ ]No
Anemia	[ ]Yes [ ]No	Measles	[ ]Yes [ ]No	Prostate Problem	[ ]Yes [ ]No
Anorexia	[ ]Yes [ ]No	Migraine Headaches	[ ]Yes [ ]No	Rheumatoid Arthritis	[ ]Yes [ ]No
Appendicitis	[ ]Yes [ ]No	Miscarriage	[ ]Yes [ ]No	Rheumatic Fever	[ ]Yes [ ]No
Arthritis	[ ]Yes [ ]No	Mononucleosis (Mono)	[ ]Yes [ ]No	Scarlet Fever	[ ]Yes [ ]No
Asthma	[ ]Yes [ ]No	Multiple Sclerosis	[ ]Yes [ ]No	Stroke	[ ]Yes [ ]No
Bleeding Disorders	[ ]Yes [ ]No	Mumps	[ ]Yes [ ]No	Thyroid Problems	[ ]Yes [ ]No
Breast Lump	[ ]Yes [ ]No	Osteoporosis	[ ]Yes [ ]No	Tuberculosis	[ ]Yes [ ]No
Bronchitis	[ ]Yes [ ]No	Pacemaker	[ ]Yes [ ]No	Tumors, Growths	[ ]Yes [ ]No
Cancer	[ ]Yes [ ]No	Parkinson's Disease	[ ]Yes [ ]No	Ulcers	[ ]Yes [ ]No
				Other_____	[ ]Yes [ ]No

How Much Do You Exercise: [ ]None [ ]Moderate [ ]Daily [ ]Heavy

Activities at Work: [ ]Sitting [ ]Standing [ ]Light Labor [ ]Heavy Labor

Are You Pregnant?: [ ]Yes [ ]No Due Date:_____

Habits:
[ ]Smoking Packs/Day: _____
[ ]Alcohol Drinks/Week:_____
[ ]Coffee/Caffeine Cups/Day: _____
[ ]High Stress Reason: _____

Please list any medications that you are currently taking: _____

Do you have any allergies? If yes, please list them here:_____

Are you taking any vitamins, herbs, or other supplements?_____

Please list any automobile accidents, head injuries, broken bones, dislocations,
and other surgeries/injuries you have had: _____

_____

Patient Signature:_____ Date:_____

Signature of Guardian (if patient is a minor): _____