Athlete's Touch Massage Therapy

Dr. David G. Doiron DC, MS, CSCS

NAME _____ DATE OF BIRTH _____

ADDRESS _____ SEX M_____ F_____

CITY _____ SOC. SEC. # _____

STATE & ZIP CODE _____ HOME PHONE # _____

EMERGENCY CONTACT NAME _____ EMERGENCY PHONE# _____

EMPLOYER _____ BUSINESS PHONE# _____

PRIMARY CARE PHYSICIAN _____ **Cell** _____

REFERRING DR. _____ **Email** _____

ATTORNEY _____

Please check the appropriate type of claim and complete the corresponding information box below.

_____WORKERS COMP _____AUTO ACCIDENT _____HEALTH INSURANCE

PRIMARY HEALTH INSURANCE INFORMATION

HEALTH INS _____ SUBSCRIBER _____

ADDRESS 1 _____ ADDRESS 1 _____

CITY _____ CITY _____

STATE _____ ZIP _____ STATE _____ ZIP _____

GROUP # _____ RELATION TO SUBSCRIBER _____

CERT. # _____ DATE OF BIRTH OF SUBSCRIBER _____

TELEPHONE _____

SECONDARY HEALTH INSURANCE

HEALTH INS _____ SUBSCRIBER _____

ADDRESS 1 _____ ADDRESS 1 _____

CITY _____ CITY _____

STATE _____ ZIP _____ STATE _____ ZIP _____

GROUP# _____ RELATION TO SUBSCRIBER _____

CERT# _____ DATE OF BIRTH OF SUBSCRIBER _____

TELEPHONE _____

WORKERS COMPENSATION OR AUTO ACCIDENT INFORMATION

SUBSCRIBER _____ INSURANCE CO. _____

ADDRESS 1 _____ ADDRESS 1 _____

CITY _____ CITY _____

STATE _____ ZIP _____ STATE _____ ZIP _____

TELEPHONE _____ TELEPHONE _____

CONTACT _____ CONTACT _____

DATE OF INJURY _____ CLAIM # _____

RELEASE OF INFORMATION AND AUTHORIZATION TO PAY

I AUTHORIZE DOIRON CHIROPRACTIC TO RELEASE ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM, AND TO INFORM MY PHYSICIAN, LAWYER, INSURANCE OR EMPLOYER OF MY STATUS. I HAVE BEEN INFORMED THAT DOIRON CHIROPRACTIC WILL PROTECT ALL INFORMATION FROM UNAUTHORIZED USE OR RELEASE OTHER THAN THAT USED TO PROCESS MY CLAIM AND MANAGE MY CARE. HEALTH INFORMATION PRIVACY RULES HAVE BEEN EXPLAINED TO ME.

I AUTHORIZE INSURANCE PAYMENT BENEFITS DIRECTLY TO DOIRON CHIROPRACTIC. I UNDERSTAND THAT INSURANCE MAY NOT PAY FOR ALL THE SERVICES I RECEIVE AND THAT I AM RESPONSIBLE TO PAY DOIRON CHIROPRACTIC FOR SERVICES OR MATERIALS PROVIDED TO ME THAT ARE NOT PAID BY INSURANCE.

SIGNATURE OF PATIENT _____ ***DATE*** _____

PATIENT & FAMILY HISTORY

What is your occupation?_____
Do you use tobacco? ☐ No ☐ Yes Explain Usage:_____
Do you consume alcohol? ☐ No ☐ Yes Explain Frequency:_____
Do you have a history of substance abuse? ☐ No ☐ Yes Explain:_____
List all past medical conditions _____
List your family medical history (diabetes, rheumatoid arthritis, heart attacks, etc)_____
List all past surgeries _____
List all drug allergies _____
List all current medications _____

SYMPTOM SURVEY

What is your chief problem or symptoms? _____

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? ☐ No ☐ Yes, who:_____

Have you had this problem or symptoms In the past? ☐ No ☐ Yes, explain: _____

Have you tried any other treatments for this? ☐ No ☐ Yes, explain:_____

Is the problem or symptoms getting worse? ☐ No ☐ Yes, explain:_____

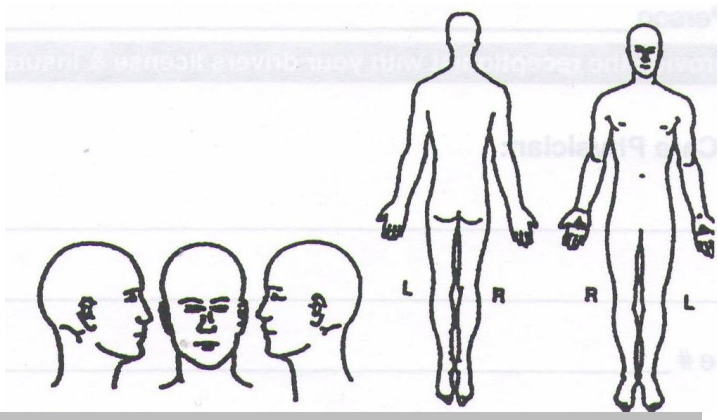
☑ THE BOX OF SYMPTOMS WHICH YOU **NOW** HAVE OR HAVE HAD IN THE **PAST**

__Arthritis	__Neck Spasms	__Wrist or Hand Pain	__Irregular Bowels	__Eye Pain—Strain
__Depression/Anxiety	__Neck Stiffness	__Low Back Pain	__Headaches	__Bleeding Gums
__Pregnancy	__Arthritis In Neck	__Abdominal Pain	__Jaw Pain	__Thyroid Problems
__Seasonal Allergies	__Chest Pain	__Diabetes	__Swallowing Difficulty	__Asthma/Bronchitis
__Dizziness	__Chest Congestion	__Groin or Rectal Pain	__Heart Attack	__Foot/Ankle Pain
__Balance Problems	__Shortness of Breath	__Female Disorders	__Hip/Knee/Leg Pain	__Fever or Chills
__Ringing in Ears	__Irregular Heart Beat	__Broken Bones	__Urinary Problems	
__Blurred Vision	__Mid Back Pain	__Digestive Problems	__Pain Worse at Night	
__Neck Pain	__*Shoulder/Elbow* Pain	__Nausea-Vomiting		

PAIN DRAWING

Draw location of your symptoms on body
Outline using the symbols for the type of sensation.

Pain ::::::::::::::
Numbness ++++++
Ache xxxxxxx
Burning ///////
Rate your Pain on a Scale of _____
I (mild) to 10 (severe)



IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

☐ Auto Accident Date _____ Time ____ [am] [pm] Location_____
Were You ☐ Driver ☐ Passenger Wearing a Seat Belt ☐ YES ☐ NO
☐ Unconscious ☐ Treated in E.R. Transported by Ambulance ☐ YES ☐ NO
Vehicle Damage ☐ Minimal - Moderate ☐ Severe - Totaled Was the vehicle towed away ☐ YES ☐ NO
Police Report ☐ None ☐ Yes with Police Dept _____
Activities ☐ No restrictions ☐ Missed ____ days of work or school ☐ I felt fine before the accident

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☐ Work Related or Other Injury Date _____ Time ____ [am] [pm] Type of Injury_____
☐ No restrictions ☐ Missed ____ days of work or school ☐ I felt fine before the injury