

Dr. Don Lounsbury
2600B Lebanon Pike
Nashville, TN 37214
(615) 883-9000



Date _____

File # _____

PATIENT RECORD

Name _____

Street Address _____ Apartment # _____

City/State/Zip _____

Home Phone _____ Work Phone _____ ext. _____

Cell Phone _____ E-mail _____

Occupation _____ Employer _____

Date of Birth _____ Social Security Number _____

Marital Status (Check) Single Married Widowed Separated Divorced

Spouse's Name _____ Date of Birth _____ Employer _____

Children _____ Ages _____ Name of Nearest Relative _____ Phone _____

Referred by: Other doctor _____ Friend _____

Yellow Pages Provider directory Sign T.V. Radio Newspaper Mailer

Health Information

Have you had previous chiropractic care? _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is your condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

Have you had loss of work time? Yes No If Yes, date you returned to work _____

How long has it been since you really felt good? _____

Other doctors who have treated this condition _____

List surgical operations and years _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers Insulin "Pep" pills

Birth Control Tranquilizers Others _____

Have you ever broken any ribs or spinal bones? Yes No

Do you have any plastic or metal in your body? Yes No

If so, where? _____

Have you ever had a stroke, heart attack or blood vessel disease? Yes No

If so, explain _____

Have you been involved in an auto accident? Past year Past five years Over five years

Describe _____

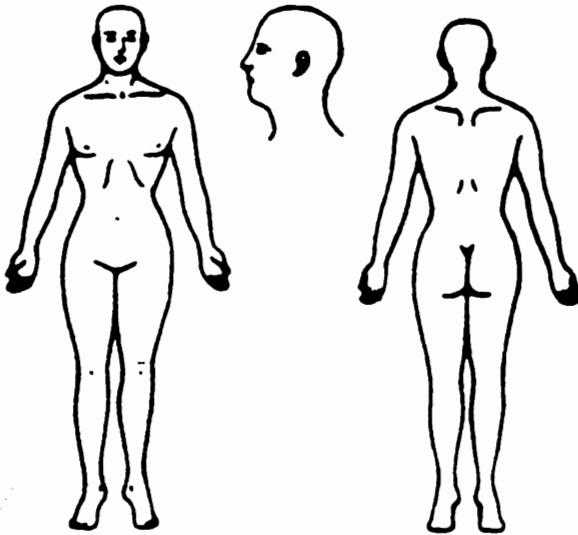
Have you any other personal injury or accident? Past year Past five years Over five years

Describe _____

Date of last physical examination _____

Do you exercise on a regular basis? _____

Please mark your areas of pain on the figures below.



Have you ever suffered from:

- 1. Dizziness _____
- 2. Backaches _____
- 3. Heart trouble _____
- 4. Diabetes _____
- 5. Arthritis _____
- 6. Headaches _____
- 7. Asthma _____
- 8. Neuritis _____
- 9. Digestive disorders _____
- 10. Nervousness _____
- 11. Skin trouble _____
- 12. Neck pain _____

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? Yes No

Do you have health insurance? Yes No

If yes, name of company _____ Policy # _____

Are you covered by Medicare? Yes No

If yes, health insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature: _____ Date: _____

Guardian or Spouse's signature: _____ SS #: _____

Doctor's signature: _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will gives us a better picture of your total health picture.)

<u>NAME</u>	<u>RELATION</u>	<u>PAST AND PRESENT HEALTH PROBLEMS</u>