LAST NAME: FIRST NAME: DATE:

GENERAL INFORMATION

PATIENT'S NAME: ______________________ ______________________ **PHONE 1:** ______________________
Last name **First** name Area Code + Home/cell

ADDRESS: ____ **PHONE 2:** ______________________
Street + Apt # if applicable Area Code + Work

______________________ ________ ________ **DL/SSN:** ______________________
City State Zip Driver's Lic. # + State **OR** SSN

BIRTH DATE: ________ ______________________ **REFERRED BY:** ______________________
Age MM/DD/YYYY

Major Complaint - designate L or R if applicable, also list providers seen for this (M.D., P.T., other therapists etc)

Other Complaints - please designate L or R if applicable

OTHER PROVIDERS: ____
Other physicians, providers seen within the past year - describe

MEDICATIONS: ____
Any medications you are currently taking

HEALTH HISTORY

SURGERIES: ____
Previous surgeries & year(s)

FRACTURES/CONCUSSIONS: ____
Previous fractures, dislocations, concussions & year(s)

ACCIDENTS & ILLNESSES: ____
Previous accidents, major illnesses & year(s)

FAMILY PHYSICIAN: ____
Name, City/Town, Phone Number (area code + number)

LAST NAME: FIRST NAME: DATE:

PRESENT SYMPTOMS

HEAD/TMJ & NECK (Including headaches, vision loss, dizziness, TMJ syndrome - describe)

UPPER EXTREMITY (Shoulders, elbows, hands, fingers - describe and note L or R side)

UPPER/MID BACK (Including ribs - describe)

LOW BACK (Including pelvis, sciatica - please describe)

LOWER EXTREMITY (Hips, legs, knees, feet) - describe and note L or R side)

CHEST, ABDOMEN & ANYTHING ELSE NOT COVERED ABOVE
(Examples: asthma, cough, heart, breast pain, nausea, constipation, heartburn - describe)

LAST NAME: FIRST NAME: DATE:

FEE POLICY & SCHEDULE

As a courtesy and with respect for your time, a specific day and time for your appointment is set aside. In the event that you cannot keep your appointment with us, please notify us 24 hours beforehand. Failure to notify us will result in a charge for the missed appointment.

I understand that the care provided by Dr. Hsu is on a cash, check or charge basis at this time, and that I will be provided with a receipt for services and payment, which may be sent to my private insurance company for appropriate reimbursement. Special arrangements may be made for payment through your insurance company. Please contact the office for further details. I am acknowledging that I am ultimately responsible for any open balances on my account for services provided by Dr. Hsu regardless of the designated payor.

Fee Schedule

First Treatment	Please call for specific charges
All other treatments	Please call for specific charges

Treatments requiring extra time will be charged accordingly

By signing this form I am stating that I, the patient, have filled out this form to the best of my ability, read, understand all the contents of the form, and am 18+ years old. If I am under 18 years old, my legal parent or guardian has filled out the form to the best of his/her knowledge, read, and understood all the contents of the form.

My signature or that of my legal parent/guardian also authorizes Tiana Hsu, D.C. to provide chiropractic care.

Patient Name

Patient Signature

Parent/Legal Guardian Name

Parent/Legal Guardian Signature

Date (MM/DD/YYYY)