

Tracy & Keim Chiropractic, LLC
1000 River Road
Eugene, OR 97404
Phone 689-0935
Brian Gervais, DC

Personal Information – Please Print

Name _____ Date of Birth _____ Age _____
Address _____ City _____ ST _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
SS# _____ E-Mail _____ Marital Status M S D W P
Referred by _____
Occupation _____ Employer _____
Spouse's name _____ Employer _____
Nearest relative **not** living with you _____
Address & Phone # _____
Nearest friend **not** living with you _____
Address & Phone # _____

Insurance Information

() Private Insurance () Personal Cash () Work related accident- date of injury _____
() Medicare () Home Accident () Other
() Auto Accident- date of accident _____ Attorney _____
Insurance Company Name _____ Address _____
Insured's Name _____ ID #'s _____
Have you met your deductible? () Yes () No

I understand that insurance policies are an arrangement between an insurance carrier and myself. This chiropractic office will assist in making collection from the insurance carrier, however, I understand that I am responsible for payment in full of all services rendered to me.

By signing this form, I am authorizing the release of copies of information kept in my file, which may be necessary to process claims. I am authorizing payment of medical benefits to be made directly to Tracy Chiropractic Clinic.

Patient signature _____ Date _____
Parent or Legal Guardian signature _____

In your own words, please state the problem that caused you to seek care in our office:

Have you had this problem before? () Yes () No

What have you done for treatment?

Please summarize what other health conditions you are experiencing now, or have had in the past:

Problem	Date problem started	Accident, Injury or Cause
_____ Headaches	_____	_____
_____ Neck pain	_____	_____
_____ Left arm pain	_____	_____
_____ Right arm pain	_____	_____
_____ Mid- back pain	_____	_____
_____ Lower back pain	_____	_____
_____ Left leg pain	_____	_____
_____ Right leg pain	_____	_____
_____ Hip pain	_____	_____
_____ Other	_____	_____

Have you been treated by a chiropractor? () Yes () No

If yes, Name _____ Address _____

Name & Address of your medical doctor _____

Please list all surgical operations

Date	Name of surgery	Spinal level of surgery	Hospital	Doctor
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Please list all injuries (Severe sprains, fractures, dislocations)

Type of injury	Date of Treatment	Remaining symptoms
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Please list all medications you are presently taking

Medications	How often	For what purpose
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Do you have any metal implants? () Yes () No Where? _____

Do you have high blood pressure? () Yes () No Tobacco use? () Yes () No

Are you currently pregnant? () Yes () No

Height _____ Weight _____