WELCOME TO OUR OFFICE !

Please Print

Patient's Name ____
First Middle Initial Last

Address ____
Street City State Zip

Home Phone #____________________ Sex (circle) Male Female
Area Code

Cell Phone #____________________ E-mail Address____________________

Marital Status (circle) Single Married Divorced Widowed

Date of birth ____________________ Social Security #____________________

Employment Status (circle) Student Homemaker Retired Employed

If Employed:
Employer____________________ Work Phone #____________________
Area Code

Work Address ____
Street City State Zip

Referred to our office by ____

In case of emergency, contact ____
Name Phone No.

Person (*if someone other than patient*)
responsible for payment of this account ____
Name Relationship to Patient

All fees are the responsibility of the patient or the responsible party listed above. As a courtesy to me, this office will file the insurance claim for me. However, should the balance not be paid by the insurance company, I understand it will be my responsibility to pay the account balance. I also understand that if my account is forwarded to collections, I will be responsible for any and all additional charges added to my past-due account plus any charges for litigation, attorney fees, court costs and filing fees. I hereby authorize payment to Dr. Robert Beck of benefits due me for his services as described. I also authorize the release of any and all medical information relating to this claim.

______________________________ ____________________
Signature of Patient or Responsible Party Date

Complete other side also ⇨

Primary Care Physician ____

Your general health (circle)   GOOD   FAIR   POOR

List any medications you are now taking ____

____

What are you here for today? ____

How long have you had this problem? ____

Did you see a doctor for this condition? ________ Doctor's name ________________________

Did you have X-rays, MRI, or other tests? ____

If so, where? ________________________ When? ________________________

Is your present condition related to employment? ________________

If so, please give the date of accident ________________________

Is present condition related to an automobile accident? ____________

Date of accident ________________________________

Related to any other accident? Date ________________________

Describe ____

Insurance Carrier ________________________ Phone # ________________________

Policy/Member # ________________________ Group # ________________________

If insured is someone other than patient: Name ________________________________

SS# ________________________ Date of birth ________________________

Secondary Ins. Carrier ________________________ Phone # ________________________

Policy/Member # ________________________ Group # ________________________

If insured is someone other than patient: Name ________________________________

SS# ________________________ Date of birth ________________________

PAIN DIAGRAM

NAME: ________________________________ *AGE:* ______________

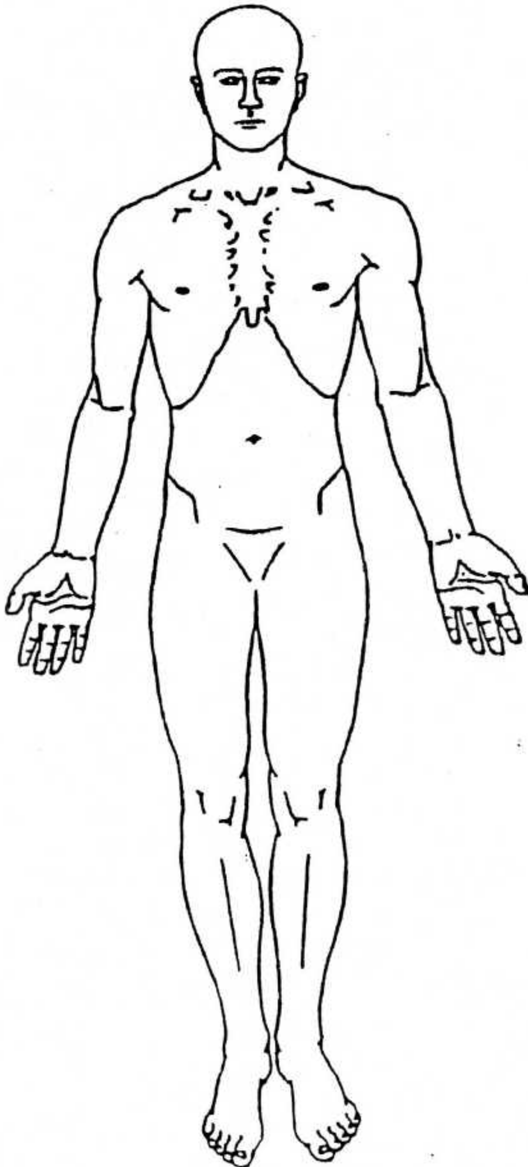
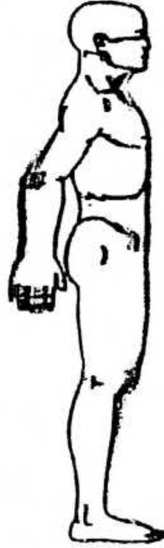
DATE: ______________________

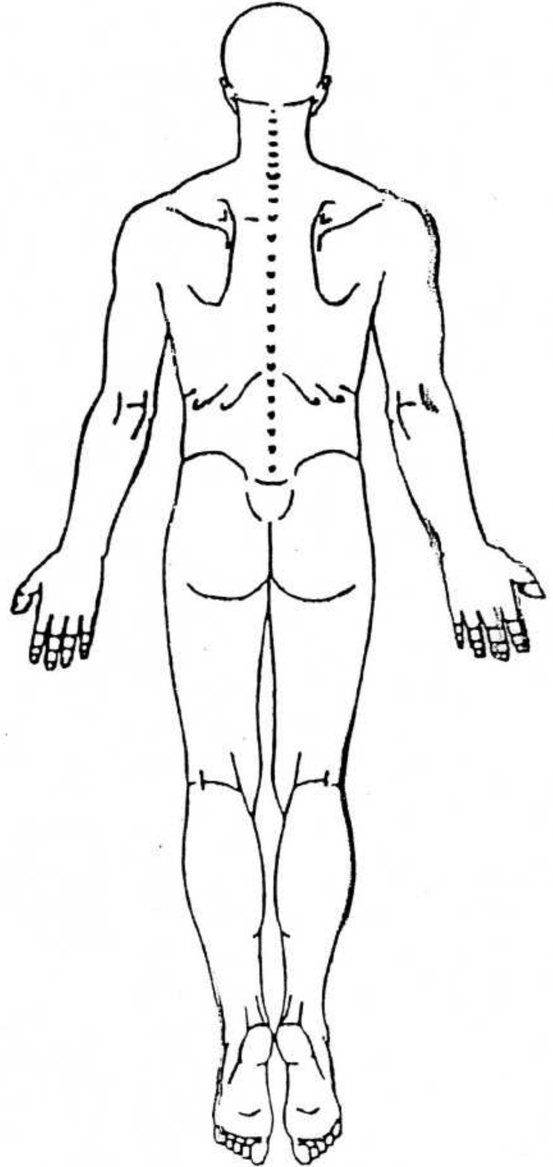
How long have you had this problem?______________________________________

Is this your first episode of this pain/discomfort?______________________________

On these diagrams, please mark where you are experiencing pain/discomfort right now.
Use the letters below to indicate the type of discomfort.

A= Ache
B= Burning
N= Numbness
P= Pins & Needles
S= Stabbing
0= Other (explain)

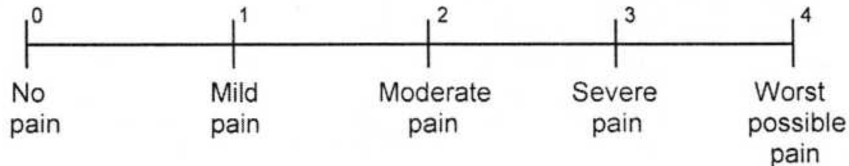


Functional Rating Index

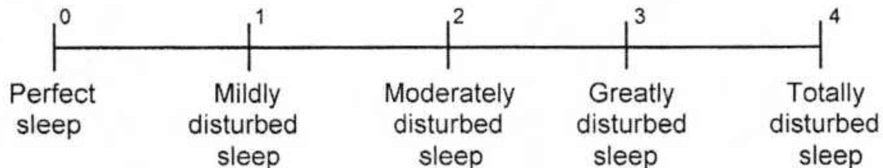
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

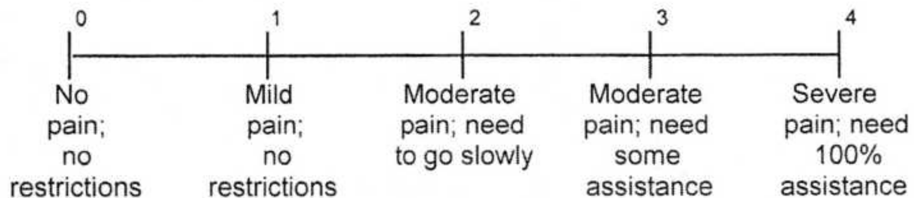
1. Pain Intensity



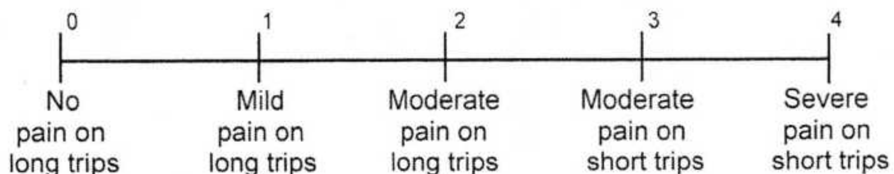
2. Sleeping



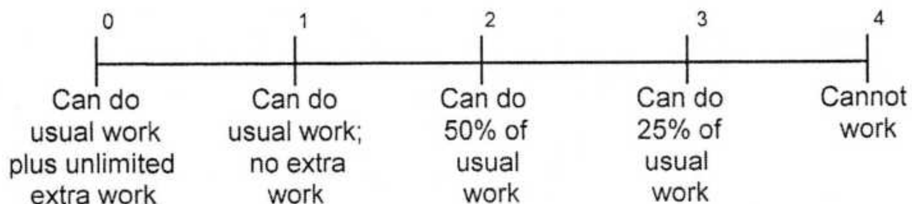
3. Personal Care (washing, dressing, etc.)



4. Travel (driving, etc.)

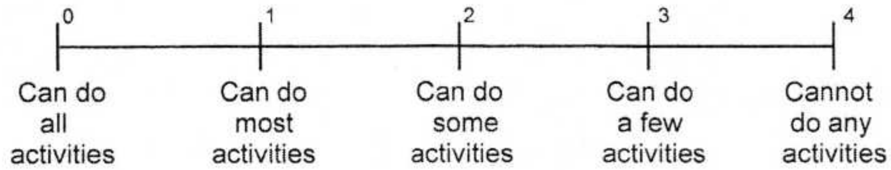


5. Work

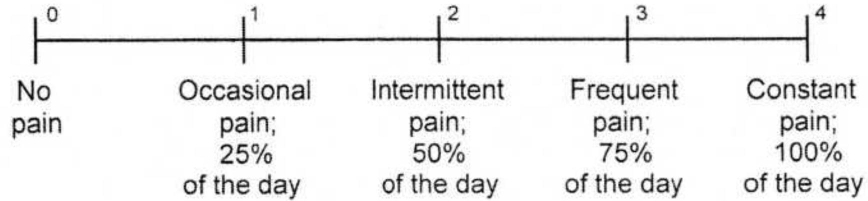


Complete other side also

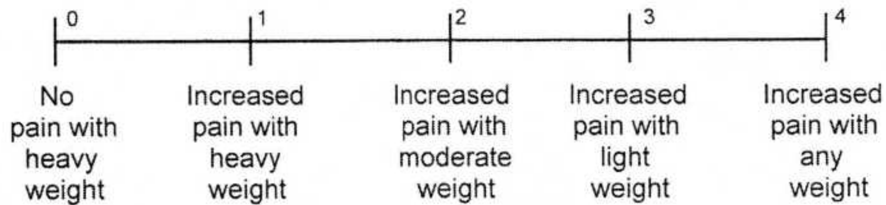
6. Recreation



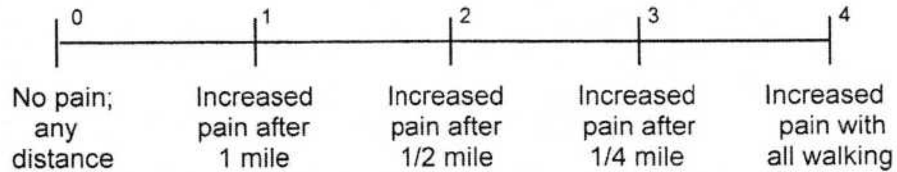
7. Frequency of pain



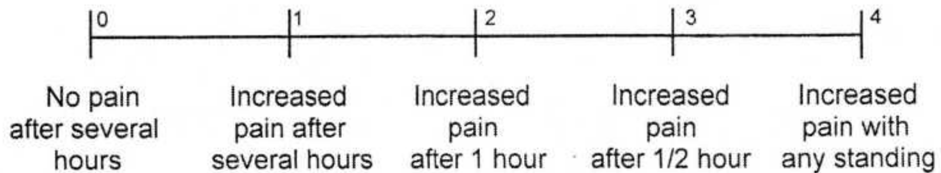
8. Lifting



9. Walking



10. Standing



Patient's Signature

Score =

Date

DR. ROBERT J. BECK

CHIROPRACTIC & REHABILITAION SPECIALTIES
2250 E. Gause Blvd., Suite 302
Slidell, Louisiana 70461-4235
(985) 643-9332/(985) 643-9285-Fax

RELEASE OF MEDICAL INFORMATION

Date:________________

To:__________________

RE: Patient:____________________

DOB:___________________________

SSN:___________________________

Please FAX any **X-RAY, CT SCANS OR MRI** Summaries that you have on file for the above-named patient. This information is needed in order for Dr. Beck to complete the patient's history and render the proper diagnosis and treatment recommendations. This information is also necessary when determining any long-term prognosis.

PLEASE FAX TO (985-643-9285). THANK YOU.

PATIENT AUTHORIZATION

As the patient, I authorize you to release the requested information to Dr. Robert J. Beck via fax number- 985-643-9285.

________________________________ ________________________________

Signature of Patient/Responsible Party Date

PATIENT: Sign this page and keep the next page **(the HIPPA Notice of Privacy Practices).**

Signature below is acknowledgment that you received a copy of the HIPPA Notice of Privacy Practices.

Signature_________________________ Printed Name_______________________ Date_______________