UPSTATE INJURY CENTER

(864) 552-1142
2520 Wade Hampton Blvd
Suite B
Greenville, SC 29615

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name | Your Social Security Number | Birth Date (MM/DD/YYYY) | Age

Your First Name | Your Middle Name (or Initial) | Gender ○ Male ○ Female | Race

Address | Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated | Ethnicity

City | State/Province | ZIP/Postal Code | Preferred Language

Home Phone | Cell Phone | Spouse's Name

Email Address | Child's Name and Ago

Emergency Contact | Emergency Contact's Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer | Work Phone

Address | May we contact you at work? ○ Yes ○ No

City | State/Province | ZIP/Postal Code | Preferred method of Contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Emal

Primary care Provider's Name

Insurance Carrier | Policy Number

Insured's Last Name | Birth Date (MM/DD/YYYY) | Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name | Insured's Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

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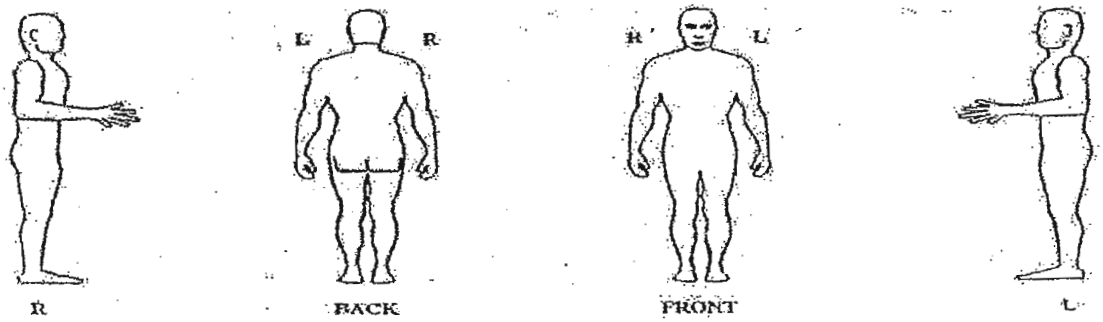
Your Name: _____

Areas of Complaint

Place **X's or Circles** on the areas where you have pain and **draw lines** to where it radiates:



Check symptoms you have noticed since the injury/ accident /slip & fall (mark all that apply)

□ Headaches	□ Irritability	□ Numbness in Toes	□ Digestive Problems	□ Face Flushed
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Shoulder Pain	□ Buzzing in ears
□ Stiff Neck	□ Dizziness/Loss of balance	□ Fatigue	□ Elbow Pain	□ Fainting
□ Back Pain	□ Head Seems to Heavy	□ Depression	□ Wrist/Hand Pain	□ Loss of Taste
□ Sore throat	□ Pins & Needles in Arms	□ Lights bother eyes	□ Upper Back Pain	□ Loss of Smell
□ Nervousness	□ Pins & Needles in Legs	□ Loss of Memory	□ Ears Ringing	□ Diarrhea
□ Tension	□ Numbness in Fingers	□ Ankle/Foot Pain	□ Heart Burn	□ Cold Sweats
□ Feet Cold	□ Hands Cold	□ Stomach Upset	□ Constipation	□ Fever

□ Bruises, cuts, scrapes and/ or scars if so please explain:

_____

□Other: _____

Is your condition getting worse? □ Yes □ No Is it Constant? □ Yes □ No Comes and Goes? □ Yes □ No

Have you already seen other doctors for this/these condition(s)? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

Doctor / Facility	Approximate Date Seen
1. _____	1. _____
2. _____	2. _____

Have you ever been involved in an accident/injury/slip & fall prior to this one? □ Yes □ No, If yes what type was it?

□ Auto □ Work □ Slip n Fall □ Leisure □ Sports □ Other _____ When?: _____

Briefly Explain: _____

Are you presently taking any medication? □ Yes □ No Please List: _____

*Signature of Patient, Parent, Guardian or Personal Representative _____

Carrano Chiropractic

Authorization Release Information and Assignment of Benefits

I hereby authorize the release of any medical information necessary to process insurance claims, including a copy of my insurance policy. I also hereby authorize payment directly to Carrano Chiropractic of all insurance benefits otherwise payable to me. should I receive payment directly from my insurance company, I will forward it immediately to Carrano Chiropractic. I understand I am financially responsible for all charges.

I understand that services rendered for a work-related injury may be covered by my employer's Worker's Compensation insurance policy. Should Worker's Compensation not provide payment for any reason, I authorize Carrano Chiropractic to bill my personal medical insurance company for payment of these services.

Please Print:

_____

First Name Last Name

_____

Signature of Responsible Party