Enos Chiropractic

P.O. Box 3261
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Dr. Andrew D. Enos

Patients Information

Date: _____

Patient Name: _____ Birthdate: _____ Sex: Male __ Female __
Address: _____ City: _____
State: _____ Zip: _____ Age: _____
Email Address: _____ Cell Number: _____
Emergency Contact: _____ Phone Number: _____
Martial Status: _ Single _Married _Other
Do you have children? __ Yes (how many?): _____ __No
Work Status: __ Employed (Full time / Part time) __ Student (Full time / Part time) __ Other
Occupation: _____ Employer: _____ Work Number:_____

Workers Compensation Injury / Auto / Personal Injury

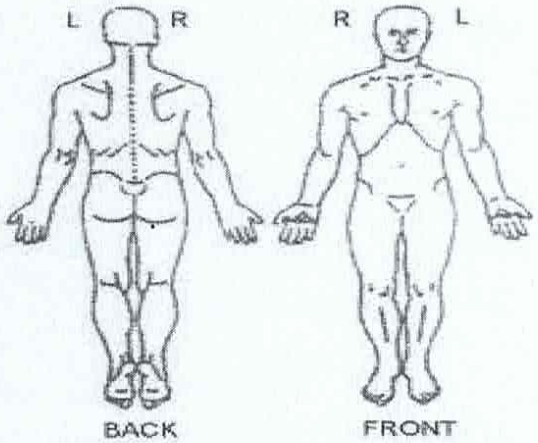
Have you filed an injury repot with your employer? _ Yes _ No Date: _____ Time: _____

Carrier: _____ Policy # _____
Carrier Phone # : _____ Adjuster: _____
Claim: _____

DESCRIBE YOUR CURRENT PROBLEM:
__Headache __Neck Pain __Mid-back Pain __ Lower Back pain
__ Other: _____
Is this? __ Work Related __ Auto Related __ N/A
Date Problem Began: _____
How Problem Began: _____

Current Complaint (How do you feel today?):

0 1 2 3 4 5 6 7 8 9 10
No Pain — Unbearable Pain



Please pinpoint your area(s) of pain

How often are your symptoms present?

_____.

In the past week, how much has your pain interfered with your daily activities? (e.g. work, social activities or household chores)

0 1 2 3 4 5 6 7 8 9 10

No interference — Unable to carry on activities