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DR. DAVID J. THOMPSON
Chiropractic Physician

9810 Lake Forest Blvd., Suite 113
New Orleans, LA 70127
(504) 241-9241

Name _____ Cell Phone _____ Home Phone _____

Address _____ City _____ State _____ Zip Code _____

Social Security No. _____ Driver's License No. _____ Date _____

Age _____ Birth Date _____ Marital Status _____ No. of Children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone _____

Patents Nearest Relative _____

Address _____

Referred by _____ Date of last physical examination _____

Have you ever suffered from:

- | | | | | | |
|-----------------|--|------------------------|--|-------------------|--|
| 1. Dizziness | Yes <input type="checkbox"/> No <input type="checkbox"/> | 6. Arthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> | 11. Nervousness | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Backaches | Yes <input type="checkbox"/> No <input type="checkbox"/> | 7. Headaches | Yes <input type="checkbox"/> No <input type="checkbox"/> | 12. Sinus Trouble | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Hear Trouble | Yes <input type="checkbox"/> No <input type="checkbox"/> | 8. Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> | 13. Anemia | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> | 9. Pinched Nerve | Yes <input type="checkbox"/> No <input type="checkbox"/> | 14. Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Tuberculosis | Yes <input type="checkbox"/> No <input type="checkbox"/> | 10. Digestion Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | 15. Chest Pain | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Purpose of this appointment _____

Other doctors seen for this condition _____

Have you been treated for any health condition by a physician in the past year? Yes No

Describe _____

Do you Smoke? Yes No Packs per day: _____ Do you Drink? Yes No Amount: _____

Have you ever had x-rays taken of your lower back? Yes No Neck? Yes No Chest? Yes No

How many days within the last year have you had trouble with your back? _____ days

How old were you when you first had trouble with your back? _____

IF YOUR INJURY IS ACCIDENTAL, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident _____ Hour _____ AM / PM Location _____

How did the accident occur? Auto Collision On-the-job injury Other

If not an auto collision, please describe the circumstances: _____

Did you report the injury to your foreman or employer? Yes No

XXXXX (they) recommend care at this office? Yes No

If an auto accident, were you Driver Passenger Pedestrian

If an auto collision, were you struck from Behind Right Left Front Car was parked

Did your car strike the other(s) involved? Yes No

Or did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No

As a result of the accident, were traffic citations issued to the other driver? Yes No

As a result of the accident, were traffic citations issued to your driver? Yes No

Describe extent of injuries as you know them _____

Do you require post-accident hospitalization? Yes No

Have you lost any days of work? Yes No Dates: _____

Insurance companies involved:

My company _____

Company of person responsible for injury _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this case? Yes No

Attorney's Name _____

Address _____ Phone No. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and my self. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____