Dr. Micah L. Randall

Office: (208) 323-8600 Fax: (208) 323-8603

10108 Overland Rd, Suite B, Boise ID 83709

Confidential Patient Information

Name: ____ Date:_______________

Home Phone: ( ) ____________________ Cell # ( )_____________________ Work: ( )________________________

Address: ____ City/State/Zip __________________________________

Email Address: ____

Which of our patients may we thank for referring you? ______________________________

Date of Birth: ____/____/____ Age:__________ Martial Status:___________ Number of Children:________

Employer: ______________________ Job Title: ____________________________________ SSN: ______________________

Name of nearest relative: ____ Phone: ( )______________________

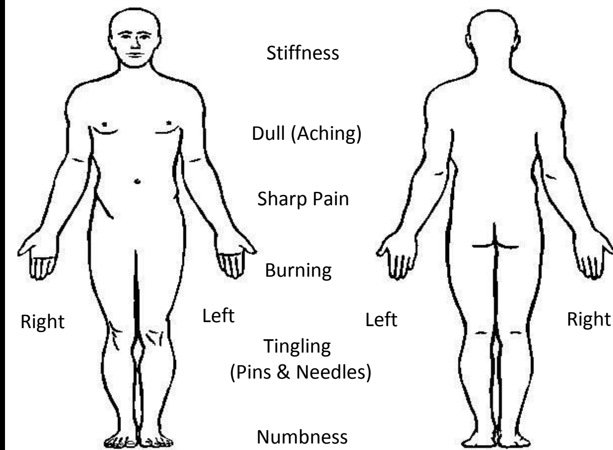
Present Complaint: Briefly describe your symptoms: ____

____

Is this visit due to an accident? [ ] Yes [ ] No If yes, where did it take place? [ ] Auto [ ] Work [ ] Other: ______________________

Pain Chart

Please mark, or shade in the areas you are have pain or discomfort. Draw an arrow from the word(s) that best discribes your pain or symptoms.



Medical History

If you have had any of the following, please check the corresponding box below.

[ ] Cancer [ ] Arthritis [ ] Diabetes [ ] Rheumatism

Surgeries: (If any, please provide dates) ____________________________

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Have you been treated by a physican in the last year?

[ ] Yes [ ] No. If yes, Condition? ______________________________

Date of last physical exam: ______________________________

Date of last Chiropratic Adjustment: ____________________________

Allergies to any medications:

[ ] Yes [ ] No. If any please list ______________________________

Are you currently taking any medications?

[ ] Yes [ ] No If any, please list ______________________________

First date of last menstrual period: ______________________

Are you now pregnant? [ ] Yes [ ] No

Payment and Insurance Information

If insurance is involved, please provide this information to the receptionist.

I understand and agree that health and accident insurance policies are an arrangement between and insurrance carrier and myself. I also 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 for my service will be credited to my account upon receipt. I permit this office to endorce co-issued remittances for the conveyance of credit to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature ____ Date: ______________________________

Spouse/Guardian's Signature ____ Date:______________________________