Dr. Micah L. Randall

Phone: (208) 323-8600

Fax: (208) 286-2023

10108 Overland Rd, Suite B, Boise ID 83709

Confidential Patient Information

Name: _____ Male ☐ Female ☐ Date: _____

Date of Birth: / / Age: _____ Phone # ( )_____ Cell ☐ Home ☐

Address: _____ City/State/Zip _____

Email: _____ Which of our patients may we thank for referring you? _____

Employer:_____ Job Title: _____

Name of nearest relative/Relacion: _____ Phone: ( )_____

Present Complaint: Briefly describe your symptoms: _____

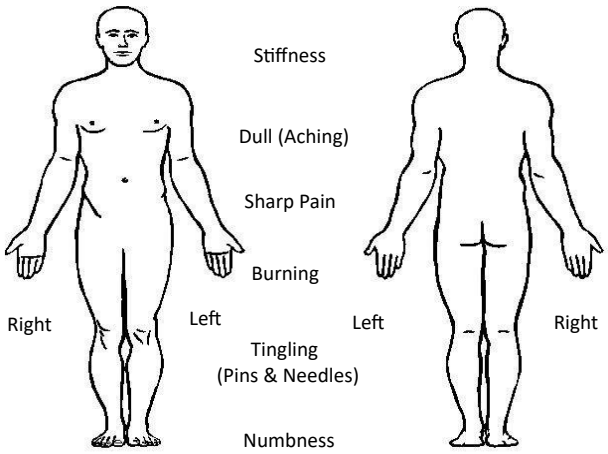
_____

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 describes 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) _____

_____ Have you been treated by a physician in the last year?

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

Date of last physical exam: _____

Date of last Chiropractic Adjustment: _____

Allergies to any medications:

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

Are you currently taking any medications?

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

Are you now pregnant? [ ] Yes [ ] No

By signing this form and providing your phone number, you agree to receive SMS Appointment Reminders from Idaho Back Pain. Message frequency may vary. Standard Message and Data Rates may apply. Reply STOP to opt out. Reply HELP for help." Once the information is entered into the system, the user receives a confirmation SMS: "Thank you for signing up for SMS updates from Idaho Back Pain.

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 insurance 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 endorse 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: _____