



Gossett Clinic of Chiropractic

2009 Fox Drive
Suite # C
Champaign, IL 61820

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www.GossettClinic.com

Chiropractic Physician
Certified Acupuncturist
Board Eligible Orthopedist

GossettClinic@gmail.com

New Patient Information

Date: _____ Patient SS#: _____
Print Name: Last _____ First _____ Middle _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Email: _____ Cell Phone: _____
Best Time and Place to reach you: _____
Male ___ Female ___ Age: _____ Birth date: _____
___ Married ___ Single ___ Minor ___ Divorced ___ Separated ___ Widowed ___ Partnered for ___ years
Occupation: _____ Employer/School: _____
Employer/School Address: _____
Spouse Name: _____ Spouse Phone: _____
Emergency Contact: _____ Relationship: _____
Emergency Phone 1: _____ Emergency Phone 2: _____

Insurance Information

Who is responsible for this account? _____ Relationship to patient: _____
Insurance Company: _____ Group #: _____
Subscriber's Name: _____ Birth date: _____
SS#: _____ Is patient covered by additional insurance? ___ Yes ___ No
Insurance Co. 2: _____ Group #: _____
Subscriber's name: _____ Relationship to patient: _____

Assignment and release

I certify that I, and/or my dependent(s), have insurance coverage with _____
(insurance company(ies)) and assign directly to Dr. T.K. Gossett all insurance benefits, if any, otherwise payable to me for
services rendered. I understand that I am financially liable for all charges whether or not paid by insurance. I authorize use
of my signature on all insurance submissions. Dr. T. K. Gossett may use my health care information and may disclose such
information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services
and determining insurance benefits or the benefits payable for related services. This consent will end when my current
treatment plan is completed and all benefits are paid by the carrier.

Signed: _____ Print: _____
Date: _____ Relationship to Patient: _____

Accident Information

Is your condition due to an accident? ___ Yes ___ No Date of Accident: _____
Type of accident: ___ Auto ___ Work ___ Home ___ Other: _____
To whom have you made a report of your accident?
___ Auto Insurance ___ Employer ___ Worker's Compensation ___ Other: _____
Attorney Name (If applicable): _____

Patient Condition

Reason for Visit: _____

When did symptoms appear?: _____

Is your condition getting progressively worse? Yes No Unknown

How bad is your pain? (1 No Pain – 10 Excruciating) _____

Please describe the area you are having pain, numbness or tingling: _____

Type of Pain: Sharp Dull Burning Throbbing Tingling Cramps
 Numbness Stiffness Aching Swelling Shooting OtherHow often do you have this pain? _____ Constant Come and GoDoes your pain interfere with Work Sleep Daily Routine RecreationActivities that are painful to perform: Sitting Standing Walking Bending Lying Down

Health History

What treatment have you had for your condition? Medications Surgery Physical Therapy
 Chiropractic None Other: _____

Name and Address of other doctor(s) that have helped you with your condition:

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test: _____

Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____

Dental X-Ray: _____ MRI/CT-Scan/Bone Scan: _____

Please put an X to indicate that you have had any of the following conditions. Leave blank if no.

Aids/Hiv:	Diabetes:	Liver Disease:	Rheumatic Fever:
Alcoholism:	Emphysema:	Measles:	Scarlet Fever:
Allergy Shots:	Epilepsy:	Migraine Headaches:	Sexually Transmitted Disease:
Anemia:	Fractures:	Miscarriage:	
Anorexia:	Glaucoma:	Mononucleosis:	Stroke:
Appendicitis:	Goiter:	Multiple Sclerosis	Suicide Attempt:
Arthritis:	Gonorrhea:	Mumps:	Thyroid Problems:
Asthma:	Gout:	Osteoporosis:	Tonsillitis:
Bleeding Disorders:	Heart Disease:	Pacemaker:	Tuberculosis:
Breast Lump:	Hepatitis:	Parkinson's Disease:	Tumors/Growths:
Bronchitis:	Hernia:	Pinched Nerve:	Typhoid Fever:
Bulimia:	Herniated Disk:	Pneumonia:	Ulcers:
Cancer:	Herpes:	Polio:	Vaginal Infections:
Cataracts:	High Blood Pressure:	Prostate Problems:	Whooping Cough:
Chemical Dependency:		High Cholesterol:	Prosthesis:
	Chicken Pox:	Kidney Disease:	Rheumatoid Arthritis:

Patient Name: _____ Date: _____

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Please Continue on Page 3: **Patient History ctd.**

Patient History Ctd.

Exercise <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Hard Labor	Habits <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Caffeine Drinks/Day _____ <input type="checkbox"/> High Stress Reason _____
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Are You Pregnant? Yes No **Due Date:** _____

Injuries/Surgeries you have had:	Description	Date
Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____
Surgeries:	_____	_____

Please list all medications you are on, allergies you have and supplements you are taking.

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name: _____	_____	_____
Pharmacy Phone: _____	_____	_____
_____	_____	_____

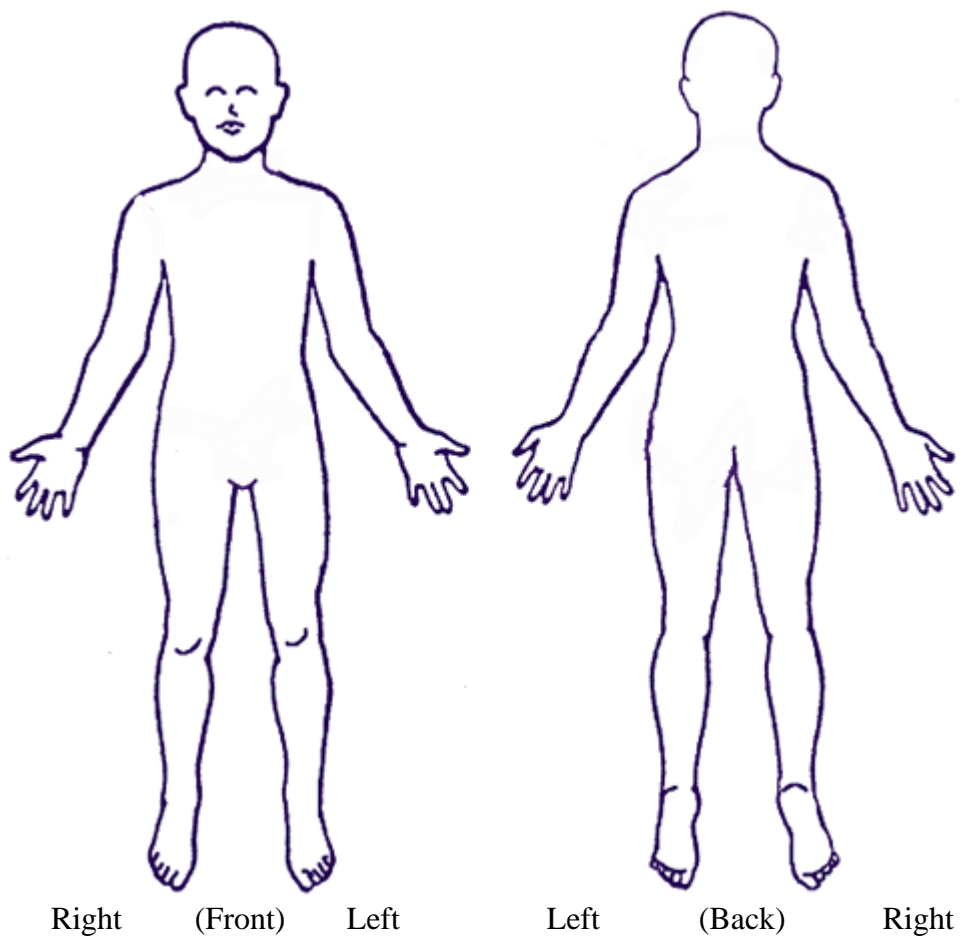
Patient Name: _____ Date: _____

Who referred you to us? _____

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Please Continue on Page 4: **Body Diagram**

Body Diagram



Please circle on the body diagram the areas where you hurt, number it and give a brief description of the problem with each.

Patient Name: _____ Date: _____

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