Chiropractic CARING FOR YOU

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1 ABOUT YOU

Today's Date: _____/_____/_____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____
CITY STATE ZIP

Home Phone #: _____ Work Phone #: _____ Ext: _____

Other Phone #s: _____ E-mail Address: _____

Employer: _____ How Long? _____

Employer's Address: _____
CITY STATE ZIP

Occupation: _____ Spouse's Name: _____

2 IN THE EVENT OF EMERGENCY

Who should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ M.D.'s Phone #: _____

3 INSURANCE INFORMATION

PRIMARY INSURANCE

Co. Name: _____

Address: _____ Phone # _____
CITY STATE ZIP

Insured's SS#: _____ Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

SECONDARY INSURANCE

Co. Name: _____

Address: _____ Phone # _____
CITY STATE ZIP

Insured's SS#: _____ Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

4 ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address _____
CITY STATE ZIP

SS# _____ Work Phone # _____

Payment method: ☐ Cash ☐ Check _____ _____/_____
☐ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office.)
Initials

5 REASON FOR VISIT

Reason for today's visit: ☐ Emergency ☐ New injury ☐ Old injury ☐ Chronic pain ☐ Wellness

Are you in pain: ☐ Yes ☐ No Rate your pain with the following scale: discomfort _____ intense
1 2 3 4 5 6 7 8 9 10

Did your injury occur during: ☐ Work ☐ Sports/play ☐ Auto Accident ☐ Routine/Household activity

When did this condition/accident occur ___/___/___ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes.

Is your condition interfering with your: ☐ Work ☐ Sleep or ☐ Daily routine? If so, how: _____

_____

Has this or something similar happened in the past?

☐ Yes ☐ No Explain: _____

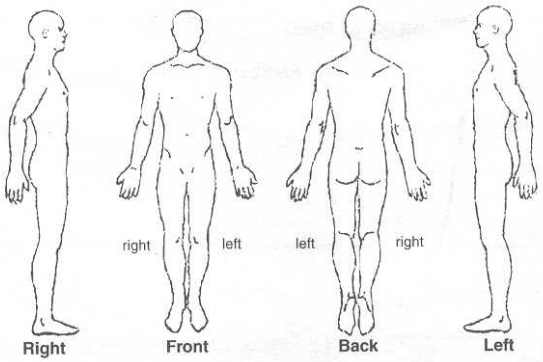
_____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No If so, where? _____

_____

Have you ever been treated by a Chiropractor? ☐ Yes ☐ No



6 HEALTH HISTORY

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Alcohol/Drug Abuse	Y N Emphysema/Asthma	Y N High/Low Blood Pressure	Y N Severe/Frequent Headaches
Y N Anemia / Diabetes	Y N Fainting/Seizures/Epilepsy	Y N HIV+/AIDS/ARC	Y N Shingles
Y N Arthritis	Y N Fractures	Y N Kidney Problems	Y N Sinus Problems
Y N Artificial Bones/Joints/Implants	Y N Frequent Neck Pain	Y N Lower Back Problems	Y N Tuberculosis
Y N Artificial Valves	Y N Glaucoma	Y N Mitral Valve Prolapse	Y N Ulcers / Colitis
Y N Cancer	Y N Heart Attack/Stroke	Y N Osteoporosis	Y N Venereal Disease
Y N Chemotherapy	Y N Heart Murmur	Y N Prostate Problems	
Y N Congenital Heart Defect	Y N Heart Surg. / Pacemaker	Y N Psychiatric Problems	
Y N Difficulty Breathing	Y N Hepatitis	Y N Rheumatic Fever	

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

_____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? ☐ Yes ☐ No Do you exercise? ☐ No ☐ Yes _____ hours per week

Do you smoke? ☐ No ☐ Yes How much? _____ How long? _____

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting: ☐ No ☐ Yes Since: _____/_____/_____

For Women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No Are you Pregnant? ☐ No ☐ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

UPDATE
(OFFICE USE)

_____ ___/___/_____
Initials Date
_____
Comments

_____ ___/___/_____
Initials Date
_____
Comments

_____ ___/___/_____
Initials Date
_____
Comments