WELCOME

one — 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 1 2 3 4 5 6 7 8 9 10 intense

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

When did your 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.

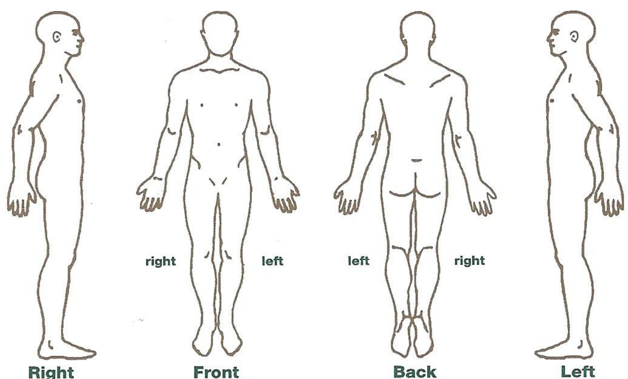
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where?________________

____

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

Clinic or Dr's name:________________

Clinic phone#:________________



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

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 woman: Are you taking Birth Control? ❑ Yes ❑ No Are you taking Hormonal Replacement? ❑ Yes ❑ No

Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks?________ ©

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

PLEASE CONTINUE ON BACK

3 three — 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: ______

Cell Phone #: (______) ____________

E-mail Address: ______________________________

Referred By: ______________________________

Employer: ____________________ How Long? ________

Employer's Address: ______________________________

CITY STATE ZIP

Occupation: ______________________________

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ______________________________

Do you have children? ❑ Yes ❑ No How many? ______

©

4 four — IN EVENT OF EMERGENCY

Whom should we contact? ______________________________

Relation: ______________________________

Home Phone #: (______) ____________

Work Phone #: (______) ____________

Cell Phone #: (______) ____________

Who is your Medical Doctor? ______________________________

Medical Doctor's Phone #: (______) ____________

©

5 five — INSURANCE INFO

Primary Insurance

Co. Name: ______________________________

Address: ______________________________

CITY STATE ZIP

Phone #: (______) ____________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ____________________

Insured's Name: ______________________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ______________________________

Please provide any Primary/Secondary Insurance cards with this form.

______ Initials — 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).

©

6 six — ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

CITY STATE ZIP

SS #: ______________________________

Drivers License #: ______________________________

Work Phone #: (______) ____________

Payment method: ❑ Cash ❑ Check

____________________________ / ______

❑ Credit Card - Enter card # above (if accepted)

©

- 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.

______ Initials **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature ______________________________ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ______ Date ___/___/___
Comments

Initials ______ Date ___/___/___
Comments

Initials ______ Date ___/___/___
Comments

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