WELCOME

HELP YOUR BODY HEAL ITSELF WITH CHIROPRACTIC

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name ______________________ Date __________ Patient No. ______ S/S _____-____-______

First MI Last

Address ______________________ City ______________ State _______ Zip ________

Sex: ☐ Female ☐ Male Birth date ____________ E-Mail Address ____________________

Home phone # ______________ Work phone # ______________ Cell Phone # ____________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Either

Preferred title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other ____________

Your employer ____________________ Occupation ____________________________

Business Address ____________________ City ______________ State _______ Zip ________

Spouse's/Parent's name ______________ Workplace ____________ Work phone # __________

Whom may we thank for referring you to us? ________________________________

Person to contact in case of emergency ______________________ Phone # ____________

Responsible Party

Name of person responsible for this account? ________________________________

Relationship to patient __________________ Phone # __________________________

Address ______________________ City ______________ State _______ Zip ________

Name of employer ____________________________________ Work phone # __________

Insurance Information

Name of insured ____________________ Relationship to patient __________________

Insurance Co. ______________________ Name of Company ________________________

Identification # ____________________ Group # ______________________________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured ____________________ Relationship to patient __________________

Insurance Co. ______________________ Name of Company ________________________

Identification # ____________________ Group # ______________________________

Daily Habits

How frequently do you exercise on a weekly basis? ☐ Never ☐ Occasionally ☐ Frequently ☐ Regularly

What activities/positions do your work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) ________________________________

What vitamins do you currently take? ________________________________

What kind of other nutritional supplements do you take (if any)? ______________________

Do you smoke? ☐ No ☐ Yes How much per day? ________________________________

How much liquor do you consume on a weekly basis? ______________________________

How much coffee or caffeinated beverages do you consume on a daily basis? ______________

~CONFIDENTIAL~

Symptoms

Reason for visit: ______________________ When did you first notice the symptoms? _______________

Is this condition getting progressively worse? ____

Where specifically is the problem(s) located? ____

Which activities are difficult to perform? □ Sitting □ Standing □ Walking □ Bending □ Lying down

□ Other ____

Type of pain: □ Aching □ Burning □ Cramps □ Dull □ Numbness □ Sharp □ Shooting

□ Stiffness □ Swelling □ Throbbing □ Tingling □ Other ____________________________

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ____

What treatment have you already received for this condition? Where was it done?

□ X-Rays ____

□ MRI ____

□ Medication ____

□ Surgery ____

□ Physical Therapy ____

□ Other ____

Name and address of other doctor(s) who have treated you for this condition: ______________________

____

Health History

Check only those conditions which are applicable:

□ AIDS/HIV	□ Diabetes	□ High Cholesterol	□ Pneumonia
□ Allergies	□ Emphysema	□ Hypertension	□ Polio
□ Anemia	□ Epilepsy	□ Kidney Disease	□ Prostate Problems
□ Anorexia	□ Fractures	□ Liver Disease	□ Prosthesis
□ Arthritis	□ Glaucoma	□ Miscarriage	□ Psychiatric Care
□ Asthma	□ Goiter	□ Mononucleosis	□ Rheumatoid Arthritis
□ Bleeding Disorders	□ Gout	□ Multiple Sclerosis	□ Stroke
□ Breast Lump	□ Headaches	□ Mumps	□ Thyroid Problems
□ Bronchitis	□ Heart Disease	□ Osteoporosis	□ Tuberculosis
□ Bulimia	□ Hepatitis	□ Pacemaker	□ Tumors, Growths
□ Cancer	□ Hernia	□ Parkinson's Disease	□ Ulcers
□ Chemical Dependency	□ Herniated Disc	□ Pinched Nerve	

□ Other ____

____

Dates of last exams ____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

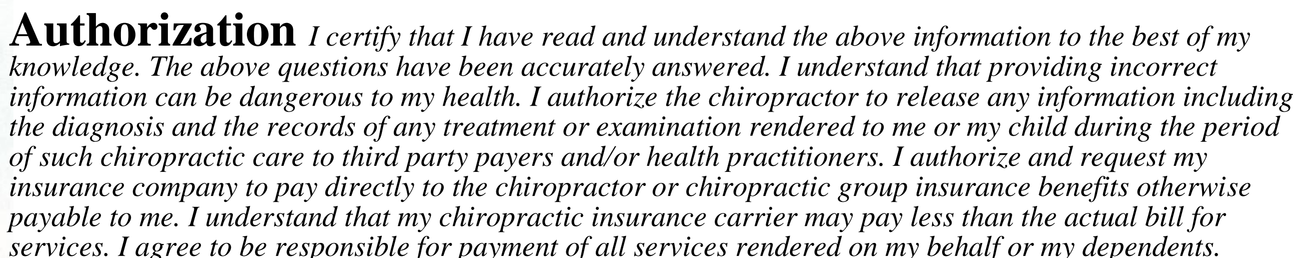
List any types of surgeries which you have had and the dates which they occurred: ____________________

____

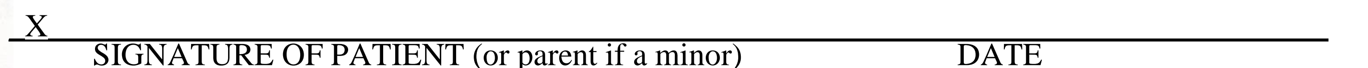
____

Please list all medications you are currently taking: ____

Allergies: ____



Authorization *I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*



X____

SIGNATURE OF PATIENT (or parent if a minor) DATE