Wehrspan Chiropractic | 924 4th St. West Des Moines, IA 50265 | 515.224.9999

Welcome!

The staff of Wehrspan Chiropractic is pleased to welcome you to our practice. Please fill out this form as completely as you can. We look forward to working with you in maintaining your health.

Patient Information

First Name_____ Nick Name_____

Last Name_____ Middle Name_____

Address_____

City_____ State_____ Zip_____

Primary Phone_____ Secondary Phone_____

Mobile Phone_____ Email_____

Birth Date_____ Age_____ Gender: ❑ M ❑ F Marital: ❑ Single ❑ Married ❑ Other

Employment: ❑ Employed ❑ Student ❑ Other ❑ Retired ❑ Self

Occupation_____ Employer_____

Spouse/Guardian Name_____

Notify in Emergency_____ Phone#_____

How Were You Referred to Us_____

Insurance Information

Name of Insured_____ Relationship to Patient_____

Address of Insured_____

Phone# of Insured_____ Birth Date of Insured_____

A copy of your insurance card must be obtained by the front desk

Acceptance as Patient

I understand that I am financially responsible for all charges, whether or not paid by insurance, for any services rendered on my behalf. This includes services that may not be a covered benefit under my insurance plan or any services they may deem not medically necessary. Any quote of my insurance benefits given to me by the staff of Wehrspan Chiropractic is given to them by my insurance company and is not a guarantee of these benefits. Also, I acknowledge I have had access to the Notice of Privacy Practices of Wehrspan Chiropractic and reviewed these if I so desired.

Patient Signature:_____ **Date:**_____

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Reason for Visit

Describe Complaints_____

_____

_____

_____

Onset Date_____ Pain Intensity (1 to 10)_____

Cause_____

Frequency: ❑ 25% ❑ 50% ❑ 75% ❑ 100% Of The: ❑ Day ❑ Week ❑ Month

Quality: ❑ Dull ❑ Sharp ❑ Throbbing ❑ Aching ❑ Burning ❑ Tingling ❑ Numb ❑ Stiff

Worse with: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Sleeping ❑ Reaching ❑ Moving

Better with: ❑ Sitting ❑ Rest ❑ No Movement ❑ Ice ❑ Heat ❑ Medication ❑ Stretching/Exercise

Previous Treatment for Complaint:_____

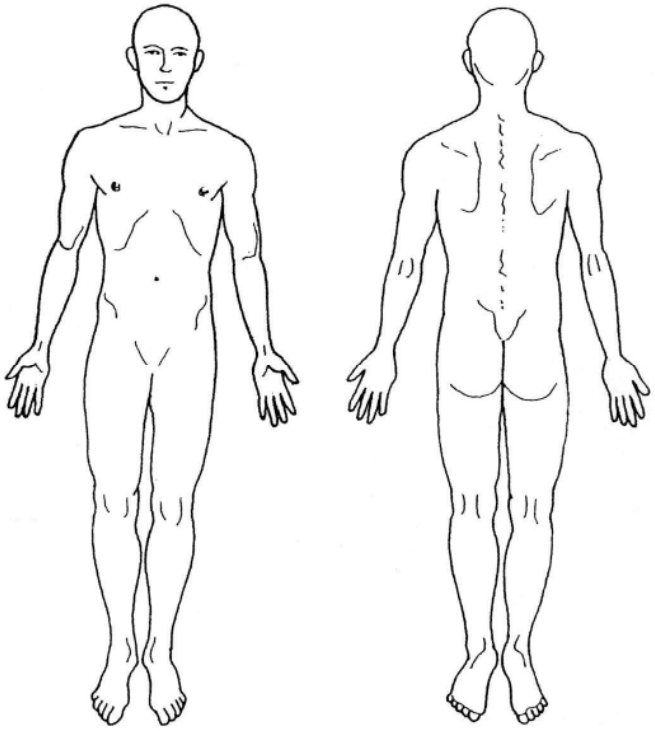
_____

Previous Chiropractic Treatment: ❑ No ❑ Yes

Who & When_____

_____

Mark an **X** on the picture anywhere you have pain →



Health History

❑ Heart Attack
❑ Diabetes
❑ Cancer
❑ Headaches
❑ Arm/Shoulder Pain
❑ Leg/Hip Pain
❑ Foot Pain
❑ Prostate Problems
❑ Artificial Joint
❑ Stroke
❑ Dizziness
❑ Pregnant
❑ Neck Pain
❑ Low Back Pain
❑ Herniated Disc
❑ Wrist Pain
❑ Osteoporosis
❑ Arthritis

Diseases, Accidents, Broken Bones, Surgeries (With Dates)_____

_____

_____

Medications_____

_____

Other Doctors Being Seen and Why_____

_____

Patient Signature:_____ **Date:**_____

Print Name:_____