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.

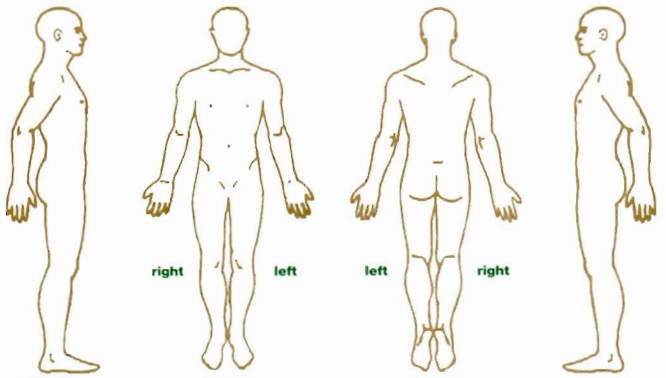
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

_____

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

Clinic or Dr's name: _____

Clinic phone#: _____



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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? _____

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PLEASE CONTINUE ON BACK

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? ____

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 #: (____) ____

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).

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