Stevensville Chiropractic Center

Please Print Clearly and Fill in Completely

Name_____ **Home Phone**_____

Address_____ **Work Phone**_____

City, State, Zip_____ **Cell Phone**_____

Birth Date_____ **Age**_____ **SS#**_____

Occupation_____ **Employer**_____

Marital Status: M W Sep. D Sin. Spouse Name_____ **No. of Children**_____

E-mail Address_____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name_____

□ Telephone Call □ Yellow Pages □ Sign □ Website □ Presentation □ E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ **□ Never**

3. When was your last complete spinal examination including x-rays? _____ **□ Never**

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
□ Yes □ No _____

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? □ Yes □ No

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? □ Yes □ No

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Please list any health symptoms or health complaints you are experiencing.
1. _____ **2.** _____ **3.** _____

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

_____

11. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?
□ Yes □ No Date of Incident_____

12. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant?
□ Yes □ No

13. Have you ever been diagnosed with cancer? □ Yes □ No

Type_____ **Year**_____

14. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations?
□ Yes □ No

15. Would you like to receive our weekly health and wellness newsletter via e-mail? □ Yes □ No

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ **Date** _____

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 on 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 you condition/accident occur? _____/_____/_____ Where did your injury occur?_____

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

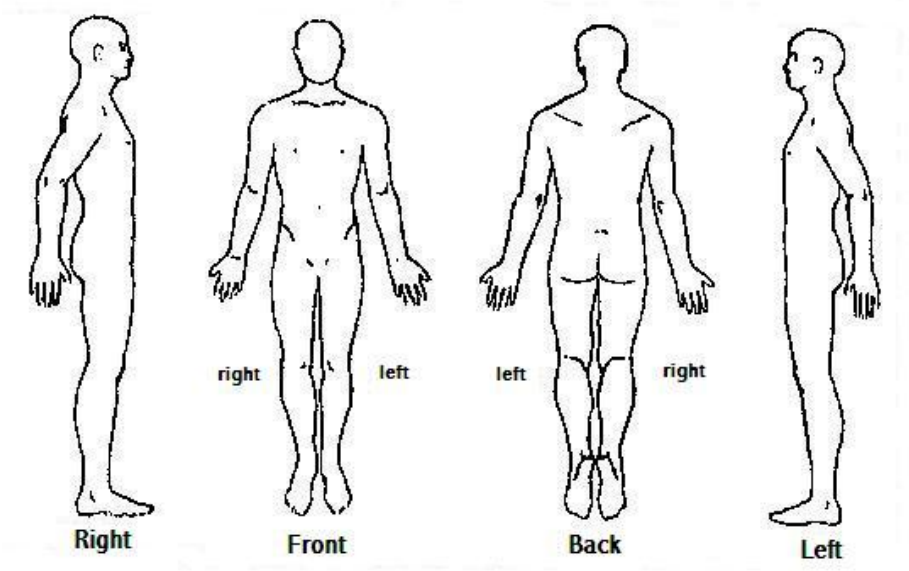
Is your condition interfering with your: □ Work □ Sleep or □ Daily routine? If so, how:_____

_____

Has this or something similar happened in the past? □ Yes □ No Explain:_____

_____

<u>Using the adjacent body charts, please circle all affected areas.</u>



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 # _____

Health History

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** Hepatitis	**Y N** Venereal Disease	**Y N** HIV + / AIDS / ARC
Y N Shingles	**Y N** Frequent Neck Pain	**Y N** Cancer	**Y N** Glaucoma	**Y N** Anemia / Diabetes
Y N High Blood Pressure	**Y N** Psychiatric Problems	**Y N** Sinus Problems	**Y N** Rheumatic Fever	**Y N** Severe / Frequent Headaches
Y N Ulcers / Colitis	**Y N** Emphysema / Asthma	**Y N** Tuberculosis	**Y N** Difficulty Breathing	**Y N** Lower Back Problems
Y N Chemotherapy	**Y N** Kidney Problems	**Y N** Fainting/Seizures/ Epilepsy	**Y N** Artificial Bones/Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and / or any other serious medical conditions not listed above:_____

_____

List any past serious accidents with dates:_____

Family Healthy History:_____

Do you take Supplements or Vitamins? □ Yes □ No Do you exercise? □ Yes □ No _____ 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: ____/____/____

Insurance Agreement

- **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.**
- **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. (Your insurance may not pay for everything, even some care that you or your health care provider have good reason to think you need.) I fully understand I am solely responsible for any balance not paid by my insurance company.**
- **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 services 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, including a fee of 10% or $25.00 whichever is greater.**
- **I understand that if I miss an appointment without calling that I will be charged a $20.00 no-show fee.**
- **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

Witness _____ Date ____/ ____/ _____