Battleground Chiropractic & Acupuncture Center
2205 Fernwood drive
Greensboro, NC 27408

Telephone: (336) 282-0170
Fax: (336) 282-3670

www.battlegroundchiropractic.com

About You:

Today's Date:____ /____/_____ File #_____

Patient Name:_____
Last First MI

What you prefer to be called:_____

___Male ___Female • Birth date:____/____/____ Age:___

Mailing Address:_____

_____
City State ZIP

Home Phone:_____

Work Phone:_____

Other 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?_____

Insurance Info:

Co. Name:_____

Address:_____

_____
City State Zip

Phone #:_____

Insured's ID #:_____

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

Insured's Name:_____

Relation:_____ DOB:__/__/__

Insured's Employer:_____

Please inform front desk of 2nd insurance source

Reasons for Visit:

Reasons 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 __Other

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.

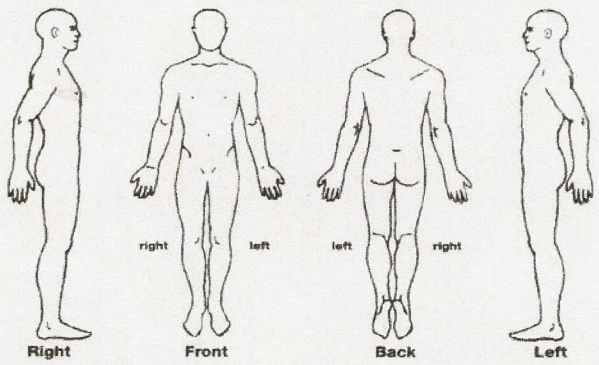
Have you been treated by a Medical Physician for this condition? __Yes __No If so, where?_____

_____

Have you ever been treated by a Chiropractor? __Yes __No

Clinic or Dr's Name:_____

Clinic phone #:_____



In event of an emergency:

Who should we contact?_____

Relation:_____

Home Phone #:_____

Who is your Medical Doctor?_____ Phone #:_____

Health History:

Are you taking any medications? Y N

_____

_____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N HIV + / Aids
Y N Frequent Neck Pain
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Fainting/Seizures Epilepsy
Y N Diabetes/Tuberculosis
Y N Lower Back Problems

Y N Heart Surg./Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles
Y N Emphysema/Glaucoma
Y N Psychiatric Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones/Joints

Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Ulcers/Colitis
Y N Asthma
Y N Chemotherapy
Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to:_____

_____

List previous surgeries/treatments with dates:_____

_____

List any past serious accidents with dates:_____

_____

Family Health History:_____

_____

Do you: Take Supplements or Vitamins? __Yes __No / Exercise? __Yes __No
Are you on a special diet: __Yes __No / Since: ___/___/___
Do you smoke? __No __Yes / How Much? _____ How Long? _____
Are you wearing: __Heel Lifts __Sole Lifts __Inner Soles __Arch Supports
What is the age of your mattress? ____ Is it comfortable? __Yes __No
For Women: Are you taking Birth Control? __Yes __No
Are you Pregnant? __No __Yes/How long? _____ Nursing? __Yes __No

- 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, 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 and or managed care organization, 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