



WELCOME

ABOUT YOU

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

Name: _____

What You Prefer To Be Called: _____ _ Male _ Female

Birthdate: ___/___/___ Age: _____ S.S.#: _____

Home Address: _____

_____ CITY STATE ZIP

Home Phone #: _____

Other Phone #s: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____ CITY STATE ZIP

Occupation: _____ Work Phone #: _____

Marital Status: _ Single _ Married _ Divorced _ Separated _ Widowed

Spouse's Name: _____



INSURANCE INFO

Co. Name: _____

Address: _____

Phone #: _____

Insured's S.S.#: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Please inform front desk of 2nd Insurance source.

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? _ Yes _ No

If so, please explain: _____

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did it begin?: ___/___/___

Is this condition getting worse? _ Yes _ No _ Constant _ Comes and goes

Is this condition interfering with your (*Please circle*): work, sleep or daily routine.

Is so, please explain: _____

Have you had this or similar conditions in the past? _ Yes _ No

Is so, please explain: _____

Have you been treated by a Medical Physician for this condition? _ Yes _ No

Is so, where?: _____



please continue on



IN EVENT OF

Who should we contact?: _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Have you ever had any of the following diseases/medical condition(s)?

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Heart Surg./Pacemaker	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Valves
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV+ / AIDS	<input type="checkbox"/> Shingles	<input type="checkbox"/> Cancer
<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Emphysema/Glaucoma	<input type="checkbox"/> Anemia
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes/Tuberculosis	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Lower Back Problems	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> 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/treatment with dates: _____

List any past serious accidents with dates: _____

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



ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

S.S.#: _____

D.L.#: _____

Work Phone #: _____

Payment method:

Cash Check Credit Card

CC# (if accepted) #: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

- 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 services and no financial arrangements have been made, you will be responsible for any 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 in my medical status.

Signature: _____ Date: ____/____/____

Please recycle so that we may preserve the health of our

