WELCOME

TO

1

ABOUT YOU

Today's Date: ______ / ______ / ______

Name: ____________________

What You Prefer To Be Called: ____________________ ☐ Male ☐ Female

Birthdate: ______ / ______ / ______ Age: ______ SS#: ______

Home Address: ____________________

CITY STATE ZIP

Home Phone #: ______________ Cell Phone# ______________

Email: ____________________

Referred By: ____________________

Employer: ____________________ How Long? ______

Employer's Address: ____________________

CITY STATE ZIP

Occupation: ______________ Work Phone #: ______________

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

Spouse's Name: ______________ Spouse's Work Phone #: ______________
Or Next Of Kin

Medical Physician's Name: ____________________

2

INSURANCE INFORMATION

Co. Name: ____________________

Address: ____________________

Phone #: ____________________

Insured's SS#: ____________________

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

Insured's Name: ____________________

Relationship? ______________ Date Of Birth: ______ / ______ / ______

Insured's Employer: ____________________

Please inform front desk of second insurance source

3

REASON FOR VISIT

Have you had previous chiropractic care? ____________________

What is your major complaint? ____________________

Other complaints? ____________________

How did condition develop? ____________________

Date of onset: ______________ Have you had same or similar problems in the past? ______

Is this condition getting worse? ☐ yes ☐ no ☐ constant ☐ comes & goes

How long has it been since you really felt good? ____________________

What aggravates your condition? ____________________

Does anything offer relief? ____________________

How would you describe your discomfort? ☐ sharp ☐ dull ☐ achey ☐ throbbing

What percent of the time does this condition bother you? ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How would you rate the level of discomfort on a scale of 0 - 10? (0=no pain 10=extreme pain)? ______

HEALTH HISTORY

Are you taking any of the following medications?

- ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ Stimulants
- ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s)

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

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 Alcolhol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
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 Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Pain	Y N Artificial Bones/Joints	Y N Arthritis

Please list all supplements, vitamins and herbs you are currently taking: ______________________________

____

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

____

Please list anything that you may be allergic to: ______________________________

____

List all previous surgeries/treatments with dates: ______________________________

____

List any and all accidents with dates: ______________________________

____

Do you exercise reqularly? ☐ No ☐ Yes / How much?__________ How long?__________

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? ☐ Yes ☐ No How Long?__________ Nursing? ☐ Yes ☐ No

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

____

SS#: ______________________________

D.L.#: ______________________________

Work Phone #: ______________________________

Payment Method:

☐ Cash ☐ Check ☐ Credit Card

CC#: (if accepted) ______________________________

Expiration Date: ______________________________

☐ 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 service 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___/___/___