

# 1 one

# WELCOME

## ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Name: \_\_\_\_\_

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

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

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: \_\_\_\_\_

# 2 two

## INSURANCE INFO

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

## 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 condition 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.

If so, please explain: \_\_\_\_\_

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

If so, please explain: \_\_\_\_\_

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

If so, where? \_\_\_\_\_

# 3 three

please continue on back.

# 4 four

## IN EVENT OF EMERGENCY

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)?

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	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 Problems	Y N Artificial Bones/Joints	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: \_\_\_\_\_

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

# 5 five

# 6 six

## 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 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*please recycle so that we may preserve the health of our planet.*

