WELCOME TO OUR OFFICE

1

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: ________

Email: ________

Referred By: ________

Employer: ________ How Long? ____

Employer's Address: ________

____
CITY STATE ZIP

Occupation: ________ Work Phone: ________

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

Emergency Contact: ________ Phone: ________

Relationship: ________

Medical Physician's Name: ________

2

INSURANCE INFO

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 condition? ________ Does anything offer relief? ________

How would you describe discomfort? ❑ sharp ❑ dull ❑ achey ❑ throbbing

What percent of 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)? ________

4

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 conditions(s)?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Mumur
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 Emphyeema/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 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 regularly? ☐ 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? ☐ No ☐ Yes / How long?____________ Nursing? ☐ Yes ☐ No

5

ACCOUNT INFO

Person ultimately responsible for account

Name: ________________

Relation: ________________

Billing Address: ________________

____

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_____/_____/______