

WELCOME 1 TO OUR OFFICE

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: _____

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: _____

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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.

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)? _____

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HEALTH HISTORY

Are you taking any of the following medications?

- Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood thinners Tranquillizers Insulin Other(s) _____

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

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

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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 ____/____/____