

# 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)? \_\_\_\_\_

Others who have treated you for this condition: \_\_\_\_\_

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