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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 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 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 supportsWhat is the age of your mattress? _____ Is it comfortable? Yes NoFor women: Are you taking birth control? Yes NoAre 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 _____ / _____ / _____