

# ABOUT YOU

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

Patient Name: \_\_\_\_\_  
LAST FIRST MI

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

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

Mailing Address: \_\_\_\_\_  
CITY STATE ZIP

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

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Other Phone #'s: \_\_\_\_\_

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

Referred by: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_

# ACCOUNT INFO

Person ultimately responsible for account

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

Relation: \_\_\_\_\_

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

CITY STATE ZIP

SS#: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

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

Payment Method:  Cash  Check

Credit Card - Enter card # above (if accepted)

Initials \_\_\_\_\_

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office)

# INSURANCE INFO

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

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

CITY STATE ZIP

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

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

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

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

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

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

## SECONDARY INSURANCE

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

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

CITY STATE ZIP

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

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

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

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

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

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

# IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

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

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

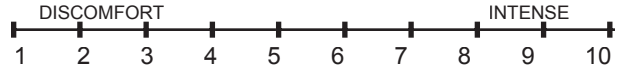
Who is your Medical Doctor? \_\_\_\_\_

M.D.'s Phone #: \_\_\_\_\_

# REASON FOR VISIT

Reason for today's visit:  Emergency  New Injury  Chronic Pain  Old Injury  Wellness

Are you in pain?  Yes  No Rate your pain on the following scale



Did your injury occur during:  Work  Sports/play  Auto Accident  Routine / Household Activity

When did your condition/accident occur? \_\_\_\_/\_\_\_\_/\_\_\_\_ Where did your injury occur? \_\_\_\_\_

Please explain what happened: \_\_\_\_\_

Is your condition getting worse?  Yes  No  Constant  Comes and goes

Is your condition interfering with your:  Work  Sleep  Daily Routine If so, how? \_\_\_\_\_

Has this or something similar happened in the past?

Yes  No Explain: \_\_\_\_\_

**Using the adjacent body charts, please circle all affected areas**

Have you been treated by a medical physician for this condition?

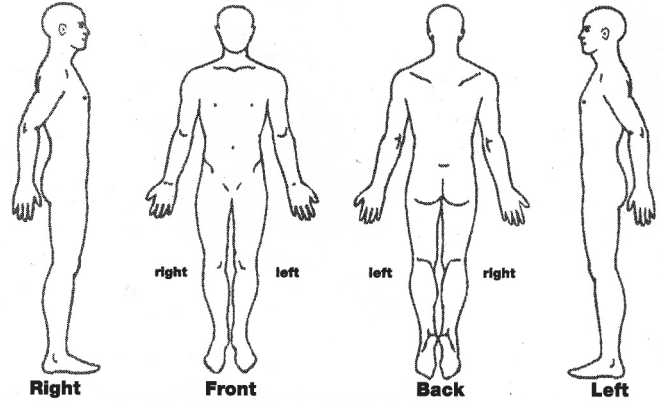
Yes  No

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

Have you ever been treated by a chiropractor?  Yes  No

Clinic or Doctor's Name: \_\_\_\_\_

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



# HEALTH HISTORY

**Are you taking any of the following medications?**

Nerve Pills  Pain Killers (including aspirin)  Muscle Relaxers  Blood Thinners  Tranquilizers  Insulin  Other

**Do you have or have you had any of the followin diseases, medical conditions or procedures?**

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

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Please list anything you may be allergic to: \_\_\_\_\_

Family health history: \_\_\_\_\_

Do you take supplements or vitamins?  Yes  No Do you exercise?  Yes  No \_\_\_\_\_ hours per week

Do you smoke?  Yes  No How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing?  Shoe lifts  Inner Soles  Arch supports Are you dieting?  Yes  No since: \_\_\_\_/\_\_\_\_/\_\_\_\_

**For women:** Are you taking birth control?  Yes  No

Are you nursing?  Yes  No Are you pregnant?  Yes  No If so how many weeks? \_\_\_\_\_

- 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 legal fees, collection agency fees, interest charges and any other 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 to the information have provided.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Initials Date

\_\_\_\_\_  
Comments

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Initials Date

\_\_\_\_\_  
Comments

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Initials Date

\_\_\_\_\_  
Comments

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Adult Patient  Parent or Guardian  Spouse