# WELCOME

## Natural Healing Through Chiropractic Care

## Patient Information

*Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

(Please Print)

Name _____ Date _____ Patient No. _____ S/S ___-___-___
First MI Last

Address _____ City _____ State _____ Zip _____

Sex: ❑ Female ❑ Male

Birth date _____ Home phone # _____ Work phone # _____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Either

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

Your employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

## Responsible Party

Name of person responsible for this account? _____ S/S ___-___-___

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

## Insurance Information

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone # ( )___-_____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

# Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1. mild pain or discomfort. to 10. severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

# Health History

Check only those conditions which are applicable:

| | | | | |
|---|---|---|---|---|
| ❑ AIDS/HIV | ❑ Cataracts | ❑ Hepatitis | ❑ Osteoporosis | ❑ Suicide Attempt |
| ❑ Alcoholism | ❑ Chemical Dependency | ❑ Hernia | ❑ Pacemaker | ❑ Thyroid Problems |
| ❑ Allergy Shots | ❑ Chicken Pox | ❑ Herniated Disc | ❑ Parkinson's Disease | ❑ Tonsillitis |
| ❑ Anemia | ❑ Depression | ❑ Herpes | ❑ Pinched Nerve | ❑ Tuberculosis |
| ❑ Anorexia | ❑ Diabetes | ❑ High Cholesterol | ❑ Pneumonia | ❑ Tumors. Growths |
| ❑ Appendicitis | ❑ Emphysema | ❑ Kidney Disease | ❑ Polio | ❑ Typhoid Fever |
| ❑ Arthritis | ❑ Epilepsy | ❑ Liver Disease | ❑ Prostate Problems | ❑ Ulcers |
| ❑ Asthma | ❑ Fractures | ❑ Measles | ❑ Prosthesis | ❑ Vaginal Infections |
| ❑ Bleeding Disorders | ❑ Glaucoma | ❑ Migraine Headaches | ❑ Psychiatric Care | ❑ Venereal Disease |
| ❑ Breast Lump | ❑ Goiter | ❑ Miscarriage | ❑ Rheumatoid Arthritis | ❑ Whooping Cough |
| ❑ Bronchitis | ❑ Gonorrhea | ❑ Mononucleosis | ❑ Rheumatic Fever | ❑ Other _____ |
| ❑ Bulimia | ❑ Gout | ❑ Multiple Sclerosis | ❑ Scarlet Fever | _____ |
| ❑ Cancer | ❑ Heart Disease | ❑ Mumps | ❑ Stroke | _____ |

Dates of last exams _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

List any types of surgeries which you have had and the dates which they occurred:

_____

_____

Please list all medications you are currently taking: _____

Allergies: _____

# Daily Habits

What type of exercise do you perform on a daily basis ? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor. heavy labor. computer work)

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? ❑ No ❑ Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

# Authorization

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X _____

SIGNATURE OF PATIENT (or parent if a minor) DATE