



WELCOME TO OUR OFFICE

Personal Information:

Today's Date: ___/___/___

File #: _____

Name: _____

Male Female

Birth date: ___/___/___

Age: _____

SSN: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

E-mail address: (for monthly newsletter/correspondence only) _____

How did you hear about us? Referral Mail Location Phonebook Walk-in Insurance Other

Who may we thank for referring you to our office? _____

Employer: _____

How Long? _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Work Phone: _____

Marital Status: Single Married Divorced Separated Widowed

Emergency Contact: _____ Phone #: _____

Relation: _____ Medical Physician's Name: _____

Insurance Information:

Do you intend to use health insurance? No Yes Are you covered by: Medicare

****Please allow our front desk staff to copy your insurance card and drivers' license****

Account Information:

Person ultimately responsible for account: Same as listed above (if different please complete below)

Name: _____ Relation: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ D.L. # _____

Home Phone: _____ Work Phone: _____

(Continued on other side)

Health History:

Are you taking any medications? No Yes _____

List any allergies or anything you are allergic to: _____

List previous surgeries: _____

Do you exercise? No Yes Times per week: _____ Intensity level: Low / Medium / High

Do you smoke? No Yes How much? _____ How long? _____

Do you drink? No Yes Times per week: _____ How many drinks? _____

For Women: Are you currently pregnant? No Yes

First day of last menstrual cycle: ____/____/____ Are you taking birth control? No Yes

Have you had any of the following diseases / medical conditions (please circle)?

- | | | | |
|------------------|------------------|------------------|-----------------------------|
| Arthritis | Asthma | Sinus Problems | Allergies/Hay fever |
| Tuberculosis | Diabetes | Epilepsy | High/Low Blood Pressure |
| Thyroid Problems | Heart Problems | Spinal Disorders | Multiple Sclerosis |
| AIDS/HIV+ | STD | Ulcer | Mental/Emotional Difficulty |
| Cancer | Polio | Kidney Problems | Serious Injury |
| Bone Fracture | Rheumatic Fever | Scoliosis | Dislocated Joints |
| Headaches | Stomach Problems | | |

List any other serious medical condition(s) you have or ever had: _____

Payment Information:

PLEASE NOTE: On your first visit, payment is due in full at the time of service, unless prior arrangements were made. We **DO** accept insurance assignment, but **NOT** until we are able to contact your insurance carrier directly to verify benefits. Payment you make today which is verified to be covered by insurance will be credited to your account, or reimbursed upon your request.

Based on this, payment today will be: ____ **Cash** ____ **Check** ____ **Credit Card (Visa, MC)**

I authorize the doctor to evaluate and care for me as he/she deems appropriate. I understand and agree that all services rendered me at this office are my financial responsibility and are charged directly to me. Even if submitted to insurance, ultimately I am personally responsible for payment.

Patient Signature _____

Date: ____/____/____

Parent/Guardian Signature _____

Date: ____/____/____

REASON FOR VISIT: (Please complete the following in detail. We will review this info during your consultation)

***** If you check YES please explain in detail *****

Have you had previous chiropractic care? No Yes _____

What is your major health concern? _____

Do you have any other health concerns? No Yes _____

How did condition develop? _____

How long have you been suffering with this health problem? _____

Have you had same or similar problems in the past? No Yes _____

Is this problem getting worse? No Yes _____

How long has it been since you really felt healthy? _____

What makes the problem worse? _____

What makes the problem better? _____

How would you describe the symptoms? Sharp Dull Ache Throbbing Burning Other _____

What percentage of time does this condition bother you? 0% 25% 50% 75% 100%

Does it wake you up at night or keep you from getting rest? No Yes _____

How would you rate the level of discomfort on a scale of 0-10 (0 = no pain / 10 = extreme pain)? _____

Does the condition travel to other parts of your body? No Yes _____

Time of day condition seems to be at its worse? Morning / Afternoon / Evening / Night _____

Have you had any recent falls/accidents/injuries? No Yes _____

Have you had any accidents/injuries in the past? No Yes _____

How does this condition impact or limit your life/daily activities? _____

Others who have treated you for this condition? _____

Additional information regarding your health. _____