

# WELCOME

## 1 one

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

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

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

Employer's Address: \_\_\_\_\_  
CITY STATE ZIP

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

Status:  Minor  Single  Married  Divorced  Separated  Widowed

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

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

## 2 two

### INSURANCE INFO

**Primary 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: \_\_\_\_\_

**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: \_\_\_\_\_

## 3 three

### ACCOUNT INFO

**Person ultimately responsible for account**

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

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

Billing Address: \_\_\_\_\_  
CITY STATE ZIP

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

Drivers License #: \_\_\_\_\_

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

**Payment method:**  Cash  Check

## 4 four

### IN EVENT OF EMERGENCY

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

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

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

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

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

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

~~Print Name, Lastname & phone (if accepted)~~  
*signature*  
I hereby authorize assignment of my insurance ~~benefits~~ ~~rights~~ 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).

PLEASE CONTINUE ON BACK 

## REASON FOR VISIT

Reason for today's visit:  Emergency  New injury  Old injury  Chronic pain  Wellness  
 Are you in pain:  Yes  No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense  
 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 or  Daily routine? If so, how: \_\_\_\_\_

Has this or something similar happened in the past?  
 Yes  No Explain: \_\_\_\_\_

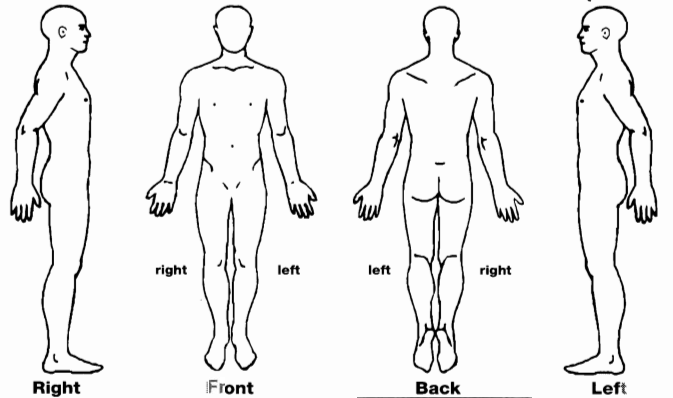
**Using the adjacent body charts, please circle all affected areas.**

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 Dr'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(s)

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

- |                             |                                |                         |                                      |                           |
|-----------------------------|--------------------------------|-------------------------|--------------------------------------|---------------------------|
| 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 / ARC     |
| Y N Shingles                | Y N Cancer                     | Y N Frequent Neck Pain  | Y N Glaucoma                         | Y N Anemia / Diabetes     |
| 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 Emphysema / Asthma               | Y N Tuberculosis          |
| Y N Difficulty Breathing    | Y N Chemotherapy               | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N 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 that you may be allergic to: \_\_\_\_\_

Family Health History: \_\_\_\_\_

Do you take Supplements or Vitamins?  Yes  No Do you exercise?  No  Yes \_\_\_\_\_ hours per week

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

Are you wearing:  Shoe lifts  Inner soles  Arch supports Are you dieting:  No  Yes Since: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**For woman:** Are you taking Birth Control?  Yes  No

Are you Nursing?  Yes  No Are you Pregnant?  No  Yes 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 I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Adult Patient  Parent or Guardian  Spouse

**UPDATE (OFFICE USE)**

Initials	____ / ____ / ____	Date
Comments		
Initials	____ / ____ / ____	Date
Comments		
Initials	____ / ____ / ____	Date
Comments		

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.