WELCOME

1 ABOUT YOU

Today's Date________________________ File # ____________

Patient Name________________________ What You Prefer To Be Called__________ Male Female
Last First MI

Mailing Address:________________________ Birthdate:__________ Age:____ SS#____________

________________________ E-Mail Address:________________________
City State Zip

Home Phone #:________________________ Other Phone #'s :________________________

Status (please check): Minor Single Married Divorced Separated Widowed

Spouse's Name: ________________________ Referred By: ________________________
Do you have children? Yes No
How Many? __________

Employer: ______________ How Long?______ Work Phone #:________________Ext: ________
Employer's Address:________________________

________________________ Occupation: ________________________
City State Zip

2a. PRIMARY 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:________________________

2b. SECONDARY 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: ________________________

3 REASON FOR VISIT

The reason for this visit is a result of (please check): work sports auto trauma chronic
(Explain what happened):____

____

Please describe the pain and its location: ________________________________

____

What date did condition begin? __________Is this condition getting worse? Yes No Constant Comes and goes
Is this condition interfering with your (please check): work sleep daily routine
If so, please explain: ________________________________
Have you had this or similar conditions in the past? (please check) Yes No
If so, please explain: ________________________________
Have you been treated by a Medical Physician for this condition? (please check) Yes No
If so, where? ________________________________
Have you ever been treated by a Chiropractor before? (please check) Yes No
If so, whom? ________________________ Phone # ________________

4 IN EVENT OF EMERGENCY

Who should we contact?________________________ Relation:________________

Home Phone #: ________________________ Work Phone #:________________

Who is your Medical Doctor? ________________________ Phone #: ________________

5 HEALTH HISTORY

Are you taking any of the following medications? (Please check all that apply)

Nerve pills Pain Killers (including aspirin) Muscle relaxers Stimulants
Blood Thinners Tranquilizers Insulin Other(s)___________________

Do you have or ever had any of the following diseases or conditions? (Please check if the answer is 'Yes')

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

Please list any other serious medical condition(s) you have or ever had

____

____

Please list anything that you may be allergic to:____

List previous surgeries/treatments with dates:____

List any **past** serious accidents with dates:____

Family Health History: ____

Do you: (please check the appropriate boxes)

Take supplements or Vitamins? Yes No
Exercise Yes No
Are you on a special diet: Yes No If yes, since what date? __________________
Do you smoke? No Yes If so, how much? ______________ How long? _____
Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports
What is the age of your mattress? _____ Is it comfortable? Yes No

For women: Are you taking Birth Control? Yes No
Are you pregnant? No Yes If Yes, How long? ______________ Nursing? Yes No

6 ACCOUNT INFO

Person Ultimately Responsible for Account

Name:_______________________________________ Relation:_______________________________________

Address: _______________________________________

____
City State Zip

SSN: _______________________________________

D.L.# _______________________________________

Work Phone #: _______________________________________

Payment method: (please check) Cash Check Credit Card

_______________________________________ ________/________
Credit Card – Enter card # above (if accepted) Expiration Date

______ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand
(Initials) that I am solely responsible for any balance not paid for by my insurance company (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 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, 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 and or managed care organization, 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 ___/___/____