

# WELCOME

# 1

## ABOUT YOU

Today's date \_\_\_/\_\_\_/\_\_\_

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

What you prefer to be called: \_\_\_\_\_

Home address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

SS#: \_\_\_-\_\_\_-\_\_\_ Gender: Male / Female

Home phone # \_\_\_\_\_

Work/Cell # \_\_\_\_\_

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

Employer: \_\_\_\_\_

How long? \_\_\_\_\_

Employer's address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Marital status: \_\_\_\_\_

\_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed

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

Emergency contact: \_\_\_\_\_

Phone number: \_\_\_\_\_

Your Medical Doctor: \_\_\_\_\_

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## REASON FOR VISIT

Have you had chiropractic care before? Yes \_\_\_ No \_\_\_

If so, please explain? \_\_\_\_\_

The reason for this visit is a result of:

\_\_\_ Work \_\_\_ Sports \_\_\_ Auto \_\_\_ Trauma \_\_\_ Chronic \_\_\_ None of these

Explain what happened: \_\_\_\_\_

Please describe the pain and its location: \_\_\_\_\_

## ABOUT YOUR CONDITION

When did it begin?: \_\_\_\_\_

Is it getting worse? \_\_\_ yes \_\_\_ no \_\_\_ constant \_\_\_ off and on

Is it interfering with: work, sleep, daily routine (please circle)

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?

\_\_\_ Yes \_\_\_ No If so, where? \_\_\_\_\_

# 2

## ACCOUNT INFO

Person ultimately responsible for account:

\_\_\_ SELF

\_\_\_ SOMEONE ELSE

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

Relationship: \_\_\_\_\_

Billing address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Date of birth: \_\_\_\_\_

Work phone: \_\_\_\_\_

Generally payment for services is required when our service is performed unless other arrangements have been made.

## How will you pay today?

\_\_\_ Cash \_\_\_ Check \_\_\_ Credit card

# 3

## INSURANCE INFO

Ins. Co. \_\_\_\_\_

Insured's name: \_\_\_\_\_

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

Relationship to you: \_\_\_\_\_

Insured Date of birth \_\_\_/\_\_\_/\_\_\_

Insured employer: \_\_\_\_\_

Please inform front desk of secondary insurance.

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**HEALTH HISTORY**

Are you taking any of the following medications?  
(please circle)

Nerve pills    Pain killers    Muscle relaxers  
Stimulants    Blood thinner    Tranquilizers  
Insulin        Other \_\_\_\_\_

Have you ever had any of the following conditions?

Heart attack/stroke     Heart surgery     Heart murmur  
 Heart defect/pacemaker     Alcohol/Drug abuse     Venereal disease  
 Hepatitis     HIV+/AIDS     Shingles  
 Cancer     Emphysema/Glaucoma     Anemia  
 Hi/Low blood pressure     Psychiatric problems     Rheumatic fever  
 Severe/frequent headache     Kidney problems     Ulcer/Colitis  
 Fainting/Seizures     Epilepsy     Asthma  
 Sinus problems/Asthma     Diabetes     Tuberculosis  
 Difficulty breathing     Chemotherapy     Arthritis  
 Lower back problems     Artificial bone/joint

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

Please list anything you are allergic to: \_\_\_\_\_

List any previous surgeries/treatments with dates: \_\_\_\_\_

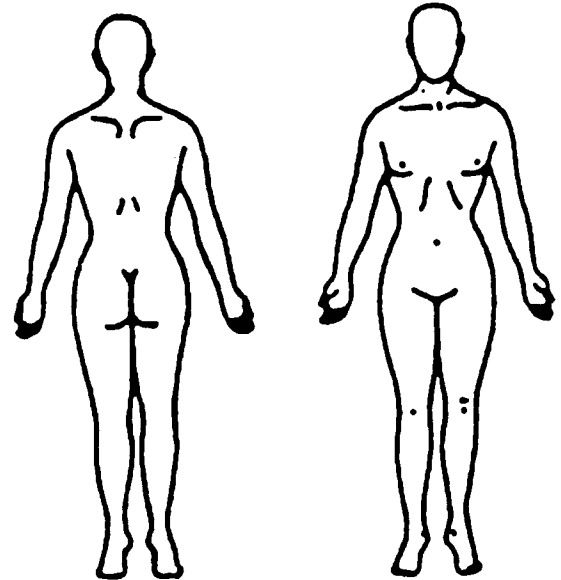
List any past serious accidents with dates: \_\_\_\_\_

Do you smoke?  No  Yes / How much? \_\_\_\_\_ How long? \_\_\_\_\_  
Are you wearing:  Heel lifts  Arch supports

For women: Are you taking birth control pills  Y  N  
Are you pregnant?  N  Y / Due date \_\_\_\_\_  
Nursing  Y  N

Please draw a picture of your areas of pain and rate severity on a scale of 1- 10.  
Use the following symbols to indicate type of pain.

\*\*aching // stabbing -- burning  
oo numb → shooting xx other



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- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor 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 office 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.

Please initial the following:

- > 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 hereby instruct and direct my insurance company and/or attorney to make payment directly to and in the name of my doctor or health care facility.
- > I understand the above information and guarantee the form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health status or insurance information.

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