

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex M F Age _____ Birth Date _____
 Single Married Widowed Separated Divorced
Patient employed by _____ Occupation _____
Business Address _____
Business Phone _____ Business Email _____
Notify in case of emergency _____ Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birth Date _____ Soc. Sec.# _____
Address (if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person responsible employed by _____ Occupation _____
Business Address _____
Business Phone _____ Business Email _____
Insurance Company _____
Phone _____ Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? Yes No If yes, when and why? _____
Your reason for *this* visit: _____
Please describe your current pain and its location: _____
When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____
Is pain getting: Worse Better Same Comes and goes How often do you have this pain? _____
Have you been treated by a medical physician for this condition? _____
If so, when and where? _____
Activities or movements that are difficult/painful to perform: Sitting Walking Bending Lying down Lifting
Type of pain: Sharp Dull Throbbing Aching Burning Tingling Numbness Cramping
 Stiffness Swelling Other _____
Is pain interfering with: Work Sleep Daily Routine Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other Serious Injuries	_____	_____

Women: Are you pregnant? Y N If so, how far along? _____ Nursing? Y N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Gout |
| <input checked="" type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Diabetes/Tuberculosis | <input type="checkbox"/> Numbness, where? _____ |
| <input checked="" type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling, where? _____ |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Shoulder Pain | <input checked="" type="checkbox"/> Emphysema/Glaucoma | <input type="checkbox"/> Muscle Spasms, where? _____ |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Artificial Bones/Joints | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Severe/Frequent Earaches | <input type="checkbox"/> HIV Positive/AIDS | |

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.