Patient Personal/Confidential Data

Date: ____________ Name: __________________________________ What You Prefer To Be Called: _________________

Home Address: ____ City/State/Zip________________________________

Home Phone #:_______________ Cell Phone #:_________________ Email: _____________________________________

Your Date of Birth: ___________________ Age: ___________ Social Security: ___________________________________

Employer Name and Address: ____

How Long? ____________ Occupation: __________________________ Work Phone #: _____________

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name or Next of Kin: __________________________________ Phone # they can be reached: ________________

Medical Physician's Name: _____________________________________ Referred by: _______________________________

Account Responsibility Information

Name of person ultimately responsible for account:

____

Relationship to you: ____________________________

Address: ______________________________________

SS#:________________ DL#: ____________________

Payment: □ Cash □ Check □ Credit Card

CC#_____________________ Expires: ______ /_____

□ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Insurance Info

Please inform the front desk of second insurance source and provide card(s).

Company Name: ______________________________

ID#: _____________________ Group #:_____________

Phone number: _______________________________

Primary Insured Name: _________________________

For Office Use Only

Reason for Visit

What is your major complaint?
____

How did condition develop? __________________________

Date of onset: ___________Have you had same or similar problems in the past? ______________________________

Is this condition getting worse?
□ Yes □ No □ Constant □ Comes/Goes

How long has it been since you really felt good?
____

What aggravates your condition?
____

Does anything offer relief? __________________________

How would you describe your discomfort?
□ Sharp □ Dull □ Achy □ Throbbing

What percent of the time does this condition bother you?
□ 0% □ 25% □ 50% □ 75% □ 100%

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

Have you had previous chiropractic care? Y or N

Have you been treated by others for this condition? Y or N

If yes, please list ___________________________________

Health History

Are you taking any of the following medications? Please circle all that apply:
Nerve pills Pain killers Muscle relaxers Stimulants Blood Thinners Tranquilizers Insulin
Other(s) ____

Have you ever had any of the following diseases/medical condition(s)?

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

You primarily sleep on your: □side □back □stomach   Do you wake feeling rested? Y or N

Please list all supplements, vitamins and herbs you are currently taking:
____

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

Please list anything that you may be allergic to:______________________________________

List all previous surgeries/treatments with dates: ______________________________________
____

List any and all accidents with dates: ____

Are you wearing: □ Heel lifts □ Sole lifts □ Inner soles □ Arch supports

Do you exercise regularly? □Yes □ No
Do you smoke? □Yes □ No

For Women: Are you taking birth control? Y or N Are you pregnant? Y or N Are you nursing? Y or N

Do you feel there are goals to reach in regard to your health? Y or N If yes, Explain: ____________________
____

Would you like to subscribe to our monthly newsletter via email? □YES □NO

▪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 any 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 in my medical status.

➧Signature____ ➧Date___/___/___