

ABOUT THE PATIENT

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Birthdate _____
Age _____ Gender M F Number of Children _____
Employer _____
Work Address _____
Work Phone _____
Type of Work _____
Marital Status Married Single Divorced
 Separated Widowed
Social Security # _____
Driver's License # _____
E-Mail Address _____
Payment Method Cash Check Credit Card
Crdt Cd. # _____ Exp. Date _____

ABOUT THE SPOUSE OR PARENT

Name _____
Employer _____
Work Phone _____
Type of Work _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to

- Job Sports Auto Fall
 Chronic Discomfort Home injury Other

Please explain _____

If job related, have you made a report of your accident to your employer?
 Yes No

When did this condition begin? _____

Has this condition gotten worse stayed constant
 comes and goes

Does this condition interfere with

- Work Sleep Daily Routine Other activities

Explain _____

Has this condition occurred before? Yes No

Explain _____

Have you seen other doctors for this condition?

- Yes No

Dr.'s Name(s) _____

Type of Treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes No

Reason for those visits? _____

Doctor's Name _____

Approximate Date of Last Visit _____

Has any *adult* in your family seen a Chiropractor? Yes No

Has any *child* in your family seen a Chiropractor? Yes No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- ...Doctors of Chiropractic work with the nervous system? Yes No
- ...the nervous system controls all bodily functions and systems? Yes No
- ...Chiropractic is the largest natural healing profession in the world? Yes No
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care** — Symptomatic relief of pain or discomfort
- Corrective Care** — Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive Care** — Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care appropriate for my condition.

Patient's Signature

Date

MEDICATIONS I NOW TAKE

- Nerve Pills
- Pain Killers (including Aspirin)
- Muscle Relaxers
- Blood Pressure Medicine
- Insulin
- Stimulants
- Blood Thinners
- Tranquilizers
- _____
- _____

HEALTH HABITS

- | | No | Yes |
|----------------------------|--------------------------------------|--|
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> ___ packs/day |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> ___ drinks/day |
| Do you drink coffee? | <input type="checkbox"/> | <input type="checkbox"/> ___ cups/day |
| Do you exercise regularly? | <input type="checkbox"/> No | <input type="checkbox"/> Moderate <input type="checkbox"/> Daily |
| Do you wear | <input type="checkbox"/> Heel Lifts | <input type="checkbox"/> Sole Lifts |
| | <input type="checkbox"/> Inner Soles | <input type="checkbox"/> Arch Supports |

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | | | |
|--|--|---|-------------------|--|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Shingles | For women: | |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Surgery/
Pacemaker | <input type="checkbox"/> Kidney Problems | | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | | Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer | | Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chemotherapy | | Do you experience painful periods?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | | |
| <input type="checkbox"/> Numbness or Pain in Arms/Legs/Hands | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic Fever | | Do you have irregular cycles? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Psychiatric Problems | | Do you have breast implants? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Problems | | |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> HIV/Aids | | | |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Diabetes | | | |
| | <input type="checkbox"/> Tuberculosis | | | |

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature

Date

Guardian or Spouse's Signature Authorizing Care

Date

Who should receive bills for payment on your account?

- Patient Spouse Parent Worker's Comp Auto Insurance
 Medicare Medicaid Personal Health Insurance

Ownership of X-ray Films.

It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

IN AN EMERGENCY, CONTACT:

Name _____

Relationship _____

Work Phone _____

Home Phone _____

ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Insurance Co. Name _____ Group Number (Plan, Local, Policy #) _____

Address _____ Phone _____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security # _____

Relation _____ Date of Birth _____

Employer _____