# WELCOME

## 1 ABOUT YOU

Today's Date: ____/____/____ File #: _____

**Patient Name:** _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

**Employer:** _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

## 2 INSURANCE INFO

Primary Insurance

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: _____

Secondary Insurance

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 ACCOUNT INFO

**Person ultimately responsible for account**

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: _____

**Payment method:** ❑ Cash ❑ Check

_____ ____/____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## 4 IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

PLEASE CONTINUE ON BACK

## 5 REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness

Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity

When did your condition/accident occur? ___/___/___ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.

Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?

❑ Yes ❑ No Explain: _____

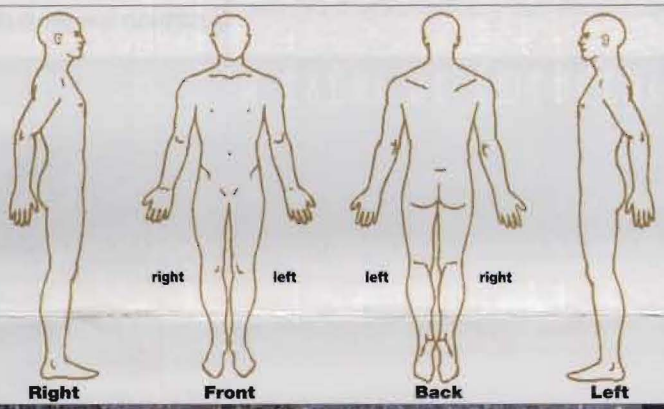
**Using the adjacent body charts, please circle all affected areas.**

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No

Clinic or Dr's name: _____

Clinic phone#: _____




## 6 HEALTH HISTORY

**Are you taking any of the following medications?** ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers

❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

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

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week

Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___

**For women:** Are you taking Birth Control? ❑ Yes ❑ No

Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- 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 legal fees, collection agency fees, interest charges 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 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 ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

**UPDATE** (OFFICE USE)

Initials ___ Date ___/___/___

Comments

Initials ___ Date ___/___/___

Comments

Initials ___ Date ___/___/___

Comments

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET