**Danville Chiropractic, 1995 East Main Street, Danville, IN 46122 Phone: 317-745-5100**

Name: ______________________________________________ Date of Birth: ______/________/_____

Nickname: ______________________________________________Social Security #_________-_________-___________

Address:__________________________________________City:___________________ State:_________ Zip:____________

E-mail address:______________________________________________________ Age:_______ Marital: ☐ **M** ☐ **S** ☐ **W** ☐ **D**

Home Phone: (_________)________________________ Cell Phone: (_______)____________________ Circle Primary Phone

Occupation:__________________________________ Employer:_______________________________________________

Employer's Address:________________________________________ Office Phone:______________________________

Spouse:____________________ Occupation:______________________ Employer:_______________________________

How many children? _______________Names and Ages of Children:_____________________________________________

Emergency Contact:______________________________________Phone:____________________________________

Who may we thank for referring you in? ____________________________________________________________

How did you hear about us? ☐ Referral ☐ Mail ☐ Newspaper ☐ Phonebook ☐ Location ☐ Insurance ☐ Walk-in ☐Other

Family Medical Doctor:________________________________________ Telephone #______________________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

## INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case:

☐ Medicaid ☐ Medicare ☐ Major Medical (Please See Note Below)

☐ Medical Savings Account & Flex Plans ☐ Other___________________________________________

Name of Primary Insurance Company: _______________________________________________________________

Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐Other ____________________________

Primary Insured Name: ________________________________________ Date of Birth: _______/________/_______

Primary ID/Member Number:____________________________________ Group #:___________________________

Name of Secondary Insurance Company (if any):____________________________________________________

Relationship to Secondary insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐Other ____________________________

Secondary Insured Name: ________________________________________ Date of Birth: _______/________/_______

Secondary ID/Member Number: __________________________________ Group #:___________________________

**AUTHORIZATION AND RELEASE**: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. **If your account should become 90 days past due your account will be submitted for collections. Any collection fees will be solely patient's responsibility.**

**PLEASE NOTE:** On your first visit, payment is due in full at the time of service, unless prior arrangements were made. **We DO accept insurance assignment, but NOT until we are able to contract your insurance carrier directly to verify benefits**. Payment you make today which is verified to be covered by insurance will be credited to your account, or reimbursed upon your request.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you want to receive your medical records, please inform our office.**

Patient's Signature: ___________________________________________________ Date: ______/______/_________

Guardian's Signature Authorizing Care:______________________________________ Date:______/______/_________

**Danville Chiropractic, 1995 East Main Street, Danville, IN 46122 Phone: 317-745-5100**

Name: ____________________________________________________________ Date of Birth: ______/________/_____

## PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

☐ Broken or Fractured Bones ☐ Osteoarthritis ☐ Eating Disorder ☐ High/Low Blood Pressure
☐ Circulatory Problems ☐ Epilepsy ☐ Alcoholism ☐ Coughing Blood
☐ Rheumatoid Arthritis ☐ Pace Maker ☐ Drug Addiction ☐ Ulcers
☐ Seizures/Convulsions ☐ Strokes ☐ HIV Positive ☐ Depression
☐ A Congenital Disease ☐ Cancer ☐ Gall Bladder ☐ Ruptures
☐ Excessive Bleeding ☐ Heart conditions ☐ Other:____________________________________

Do you have a history of stroke ☐ Yes ☐ No **or** hypertension ☐ Yes ☐ No? ________________________________

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____________________________________________________________________________________________

____________________________________________________________________________________________________

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, describe:_____________________________________________________________________________________

What medications or drugs are you taking?___________________________________________________________________

____________________________________________________________________________________________________

Do you have any allergies to any medications? ☐ Yes ☐ No
If yes, describe: ____________________________________________________________________________________

Do you have any allergies of any kind? ☐ Yes ☐ No
If yes, describe: ____________________________________________________________________________________
Please list any other health problems you have, no matter how insignificant they may be:

____________________________________________________________________________________________________
(Please use back of page for additional information)

## SOCIAL HISTORY:

Do you drink alcoholic beverages? ☐ Yes ☐ No If so, how much per week?_____________________________________

Do you use any tobacco products? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No If so, packs per day: _________________

Do you take vitamin supplements? ☐ Yes ☐ No If so, please list:________________________________________________

Do you consume caffeine? ☐ Yes ☐ No If so, how much per day:_____________________________________________

Do you exercise? ☐ Yes ☐ No If yes, what is the frequency and type of exercise?_________________________
What are your hobbies?__________________________________________________________________________
What percentage of time during the day (at home or at your job away from home) do you spend?
lifting__________% sitting__________% bending ____________% working at a computer_________%

## FAMILY HISTORY:

Father: ☐ living ☐ deceased Current age if still living:______ Cause of death and age at death if deceased: ____________________ (check one)

Mother: ☐ living ☐ deceased Current age if still living:______ Cause of death and age at death if deceased: ____________________ (check one)

Check if applicable to you: ☐ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? ☐ Yes ☐ No If so, please list:

_______________________________________________________________________________

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **C**hildren):

| | | | | | |
|---|---|---|---|---|---|
| Tuberculosis | ☐ M ☐ F ☐ B ☐ S ☐ C | Cancer | ☐ M ☐ F ☐ B ☐ S ☐ C | Mental Illness | ☐ M ☐ F ☐ B ☐ S ☐ C |
| Diabetes | ☐ M ☐ F ☐ B ☐ S ☐ C | Asthma | ☐ M ☐ F ☐ B ☐ S ☐ C | Heart Disease | ☐ M ☐ F ☐ B ☐ S ☐ C |
| Stroke | ☐ M ☐ F ☐ B ☐ S ☐ C | Kidney Disease | ☐ M ☐ F ☐ B ☐ S ☐ C | Lung Disease | ☐ M ☐ F ☐ B ☐ S ☐ C |
| Arthritis | ☐ M ☐ F ☐ B ☐ S ☐ C | Liver Disease | ☐ M ☐ F ☐ B ☐ S ☐ C | Headaches | ☐ M ☐ F ☐ B ☐ S ☐ C |
| Back Problems | ☐ M ☐ F ☐ B ☐ S ☐ C | Disc Problems | ☐ M ☐ F ☐ B ☐ S ☐ C | Pinched Nerve | ☐ M ☐ F ☐ B ☐ S ☐ C |
| Joint Problems | ☐ M ☐ F ☐ B ☐ S ☐ C | Neck Problems | ☐ M ☐ F ☐ B ☐ S ☐ C | Scoliosis | ☐ M ☐ F ☐ B ☐ S ☐ C |
| | | Multiple Sclerosis | ☐ M ☐ F ☐ B ☐ S ☐ C | Bad Posture | ☐ M ☐ F ☐ B ☐ S ☐ C |

Other ________________________________________

**Danville Chiropractic, 1995 East Main Street, Danville, IN 46122 Phone: 317-745-5100**

Name: ______________________________ Date of Birth: ____/____/____

## SUMMARY

1. What is/are your major symptom/s? ______________________________
2. What does this prevent you from doing or enjoying?______________________________
3. If this is a recurrence, when was the first time you noticed this problem?______________________________

   How did it originally occur?______________________________

   Has it become worse recently? ☐Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

   If yes, when and how? ______________________________
4. How frequent is the condition? ☐ Constant ☐ Frequent ☐ Occasionally ☐ Intermittent ☐ Night Only

   How long does it last? ☐ All Day ☐ Few Hours (range):__________ ☐ Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom?

   ☐ Yes ☐ No If yes, describe: ______________________________

   Are there other unrelated health problems? ☐Yes ☐ No. If yes, describe ______________________________

   ______________________________
6. Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

   ☐ Radiating ☐ Other ______________________________
7. Is there anything you can do to relieve the problem? ☐ Yes ☐ No. If yes, describe ______________________________

   __________. If no, what have you tried to do that has not helped? ______________________________

   ______________________________
8. What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

   ☐ Other______________________________
9. List any **major accidents or surgeries** you have had other than those that might be mentioned above

   ______________________________
10. **WOMEN ONLY**: Are you pregnant or is there any possibility you may be pregnant?

    ☐ Yes ☐ No ☐ Uncertain **First** Day of Last Menstrual Cycle:______/______/______
11. Previous Chiropractic Experience ☐ Yes ☐ No Who?______________________________
12. Other Medical Professionals Seen for Condition______________________________
13. Notes: ______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

NO SYMPTOMS ______________________________ EXTREME SYMPTOMS

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Please rate yourself 1-10, 1 being no problems and 10 being the worst pain you can imagine.