

Welcome To Our Office!

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ E-Mail _____

Social Security #: _____ Age: _____ Male Female

Marital Status: Married Single Divorced Separated Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Mail Clinic Location Other _____

Payment for Services will be by: Cash Check Credit Card Health Insurance

Automobile Insurance Worker's Compensation

Name of Insurance Co.: _____ Insured's Name: _____

Are you covered by more than one insurance company? Yes No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal dx.

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

Primary Medical Doctor's Name _____ Phone _____

SURGICAL HISTORY:

1. _____

Date: _____

2. _____

Date: _____

3. _____

Date: _____

Have you ever had a metal implant? Yes No

Any other implants? _____

ACCIDENT HISTORY : Job Auto Other 1. _____ Date: _____

Job Auto Other 2. _____ Date: _____

Job Auto Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms (1-10, with 1 being least serious)

1. _____

2. _____

3. _____

(Over Please)

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT
ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # ___ HOUR(S) ___ DAY(S) ___ WEEK(S) ___ MONTH(S) ___ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES
WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____
ARE YOU TAKING ANY MEDICATIONS NO YES WHATKIND? _____
ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD (onset) _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
- LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss confusion
- constipation depression diarrhea dizziness face flushed fainting fatigue fever
- head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste
- low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms
- pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand the providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature: (parent if a minor) _____ Date: _____

HIPPA Notice: *I understand and agree 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 a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.*

Patient's Signature: (parent if a minor) _____ Date: _____