

1  
one

# WELCOME

## 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  
two

## INSURANCE INFO

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Please inform front desk of 2nd. Insurance source.

## REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): \_\_\_\_\_

Please describe the pain & its location: \_\_\_\_\_

When did condition begin? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

If so, where? \_\_\_\_\_

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

If so, whom? \_\_\_\_\_ Phone#: \_\_\_\_\_

3  
three

PLEASE CONTINUE ON BACK 

4  
*four*

## IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_  
 Relation: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Who is your Medical Doctor? \_\_\_\_\_ Phone #: \_\_\_\_\_

## HEALTH HISTORY

### Are you taking any of the following medications?

Nerve pills  Pain killers (including aspirin)  Muscle relaxers  Stimulants  
 Blood Thinners  Tranquilizers  Insulin  Other(s) \_\_\_\_\_

### Do you have or ever had any of the following diseases or conditions?

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

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

Please list anything that you may be allergic to: \_\_\_\_\_

List previous surgeries/treatments with dates: \_\_\_\_\_

List any **past** serious accidents with dates: \_\_\_\_\_

Family Health History: \_\_\_\_\_

**Do you:** Take Supplements or Vitamins?  Yes  No / Exercise?  Yes  No

Are you on a special diet:  Yes  No / Since: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you smoke?  No  Yes / How Much? \_\_\_\_\_ How Long? \_\_\_\_\_

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

What is the age of your mattress? \_\_\_\_ Is it comfortable?  Yes  No

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

Are you Pregnant?  No  Yes/How long? \_\_\_\_ Nursing?  Yes  No

5  
*five*

6  
*six*

## ACCOUNT INFO

### Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SSN: \_\_\_\_\_

D.L.#: \_\_\_\_\_

Work Phone#: \_\_\_\_\_

**Payment method:**  CASH  Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of  
 my insurance 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).

Initials \_\_\_\_\_

- 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, 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 and or managed care organization, 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

