Welcome

Personal History

Today's Date:_____/_____/_____

Name:_____ **Male____Female____**

Birthdate:_____/_____/_____,Age:_____SS#_____

Home Address:_____
(Street, P.O. Box) (City) (State) (Zip)

Home Phone #:( )____-_____ Other Phone #'2:_____

Referred By:_____
(Newspaper, Sign, T.V., Friend or Relative)

Employer:_____**How Long:**_____

Employer's Address:_____
(City) (State) (Zip)

Occupation:_____

Marital Status:____Single,____Married,____Divorced,____Separated,____Widowed

Spouse's Name:_____**SS#**_____

Name and Number of Emergency Contact:_____

Please mark area(s) of injury or discomfort as shown below in example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain). Please Circle One.

1 2 3 4 5 6 7 8 9 10

Numbness	Pins & Needles	Burning	Aching	Stabbing
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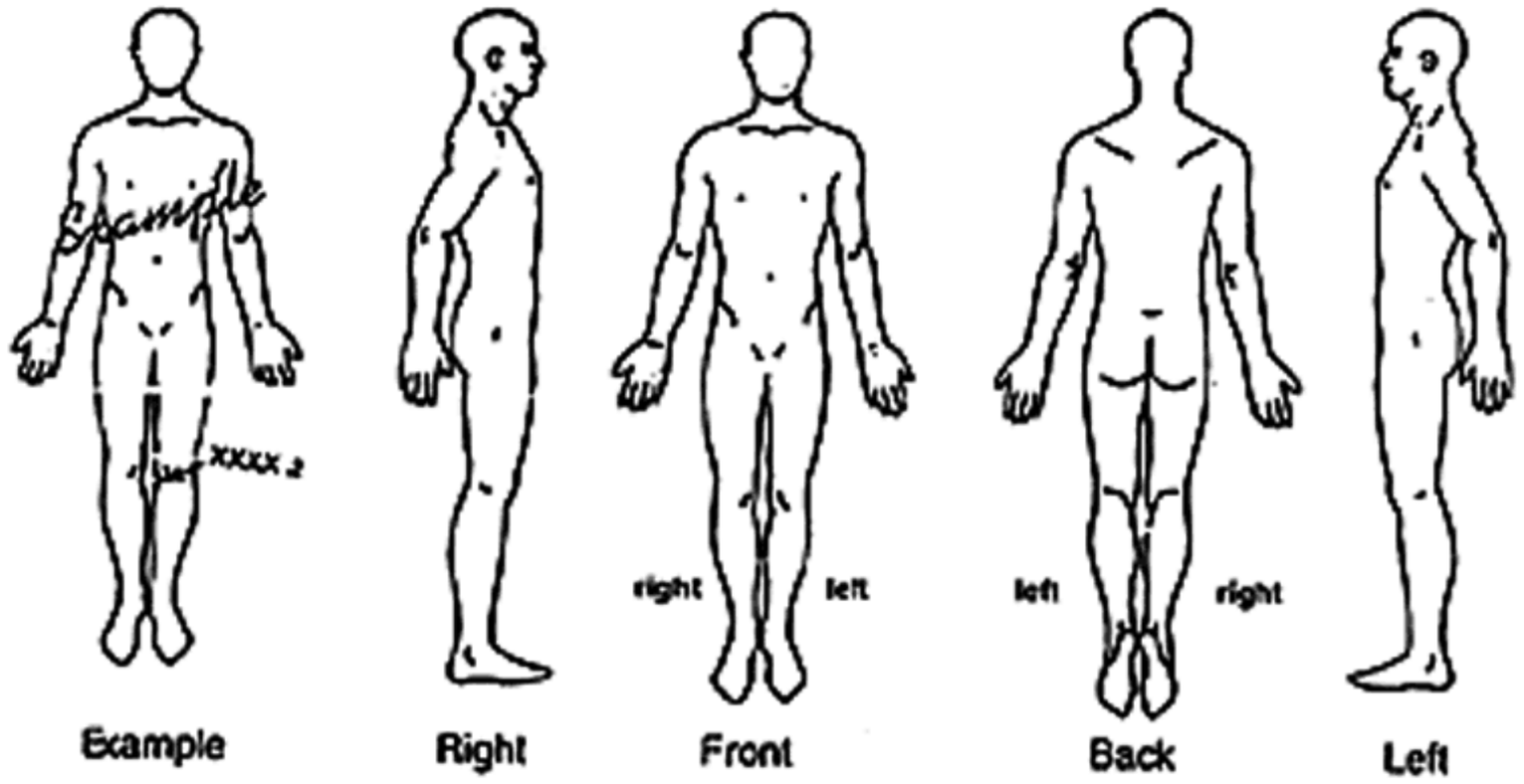

REASON FOR VISIT

Have you ever been treated by a Chiropractor before?__Yes__No. If so, explain? -------_____

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,

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.

Health History

Are You Taking Any Of The Following Medications?___Nerve Pills, ___Pain Killers, Muscle Relaxers,___Stimulants,___Blood Thinners,___Tranquilizers,___Insulin, Other(s)_____

Family Health History:_____
_____

List Any **Past** Serious Accidents With Dates:_____

Please List Any Other Medical Condition(s) You Have Or Ever Had:_____
_____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort(Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved(Corrective Care). 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 ___Corrective Care ___Check here if you want the Doctor to select the type of care Appropriate for you condition.

Date:_____Patient's Signature_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection 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. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through us of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is 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.

Patient's Signature X_____Date_____

Parent or Guardian
Signature Authorizing Care_____Date_____