Mountain West Chiropractic

Mountain West Chiropractic of Green Valley, Kenneth M Bahoora, DC & Associates
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PATIENT INFORMATION:

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name: ____ Date:____________
First Middle Last
Address: ____
City: ____________________ State: __________ Zip Code: ______________
Social Security#: _____-____-_____ Driver's License:____________________
Sex: ( ) Female: ( ) Male Birth date:____/____/____ Age:____________
E-mail Address: ______________________________ Ok to e-mail info: Y____ N ____
Home #: (____)____-_____ Cell#:(____)____-_____ Work#:(____)____-_____
Do you prefer to receive calls at: __ Home __Work __ Cell
__Single __Married __Widowed __Minor __Separated __Divorced
Employer/School: ____________________________________Occupation:________________
Address:____
City: ____________________ State: __________ Zip Code: ____________________
Emergency contact person: ____
Relationship: _________________________ Cell#: (____)____-_____ Work#:(____)____-_____
Whom may we thank for referring you to us? ______________________________________
If patient is a minor (under 18yrs old), Please fill out this section.
Parent/Guardian's Name: ____________________________Relationship:____________________
Address: ____
City: ____________________ State: __________ Zip Code:____________________
Employer:____ Occupation: ________________
Home #:(____)____-_____ Cell#:(____)____-_____ Work#:(____)____-_____

CONSENT TO TREAT A MINOR: ____
Parent/Guardian/Custodian's signature

INSURANCE INFORMATION:

Name of insured ______________________________________Relationship:________________
Birthdate: ___/___/____ SS#: _____-____-_____ Date employed____________________
Ins Co. ____ Phone#: (____)____-_____
Policy/Group#: ____
Secondary Insurance
Name of insured ______________________________________ Relationship :________________
Birthdate: ___/___/____ SS#: _____-____-_____ Date employed ____________________
Ins Co. ____ Phone#:(____)____-_____
Policy/Group#: ____

( ) I will not be utilizing any insurance benefits. ____
Initial or sign

Reason for visit ____

Is the condition related to: ( ) Work ( ) Auto ( ) Other ___________ Date of Accident: __________

What doctors have you seen for this condition? ________________________________

DAILY HABITS:

How many times per week do you exercise? ______________________________

What do your daily work habits include? ______________________________

Do you smoke? ( ) N ( ) Y if so, how many packs per day? ______________________________

Do you drink? ( ) N ( ) Y if so, how much liquor do you consume? ______________________

How much coffee or caffeinated beverages do you consume daily? ____________________

Check and/or circle only those conditions which are applicable:

__Fractured Bones	__Depression	__Ringing in ears R L	__Diarrhea/Constipation
__Irritable	__Hearing Loss R L	__Colon Trouble	__Kidney Trouble
__Tremors	__Fainting	__Hemorrhoids	__Menstrual Problem/PMS
__Allergies	__Blurred Vision R L	__Prostate Problems	__AIDS/HIV
__Sinus Problems	__Double Vision R L	__Impotence	__Bed Wetting
__Eating Disorders	__Upper Back/Stiffness	__Ulcers	__Gall Bladder Trouble
__Trouble Sleeping	__Low Back_	__Mid Back	__Dizziness
__Trouble Concentrating	__Low Back/Stiffness	__Menopausal Problems	__Cancer
__Arthritis	__Learning Disability	__Skin Problems	__Chest Pain
__Anorexia	__Mood Changes	__Difficulty Breathing	__Convulsions/Epilepsy
__Appendicitis	__Headaches	__Stroke	__Head Pain
__Asthma	__Pain/Stiff Neck R L	__Heart Problems	__Liver Trouble
__Diabetes	__Numbness/Tingling/Pain	__Jaw Pain/TMJ R L	__High /Low Blood Pressure
__Swollen/Painful Joints	__ Arms/Hands/Fingers R L	__Shoulder Pain R L	

__Numbness/Tingling/Pain buttocks ,thighs, legs, feet, toes

CERTIFICATION & ASSIGNMENT

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there are any changes in my medical status, I will inform my chiropractor. I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

______________________________ ______________

Signature *Date*