Welcome To Winnsboro Chiropractic Clinic

First Name_____ MI_____ Last Name_____ Today's date____/____/____

Address_____ City_____ State_____ Zip_____

Birth Date____/____/____ Age_____ ____ Male ____ Female ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

# of Children _____ Soc. Sec. #_____-_____-_____ E-mail Address_____

Home #( ) _____ Cell # ( )_____ Work # ( )_____

Your employer_____ Your occupation_____

Name of Spouse (Parent if patient is under 18)_____

Who may we thank for referring you to our office?_____

Your Health Profile

Mark "X" for <u>PRESENT</u> CONDITIONS or "PA" for <u>PAST</u> CONDITIONS (3 months or longer). Please 'Circle' if necessary to be more specific.

___Headaches/Migraine
___Fractured Bones
___Swollen Painful Joints
___Anemia
___Pain w/ Cough / Sneeze
___Heart Problems
___Prostate Problems
___Dizziness/Vertigo
___Fatigue
___Colon Trouble
___Cold Feet
___Foot Problems
___Cold Sweats
___High Blood pressure
___Other _____
___Numbness/Tingling/Pain in (Arms / Hands/ Fingers) R / L Both

___Hip Pain R / L
___Arthritis
___Convulsions/Epilepsy
___Tremors
___Chest Pain
___Stroke
___Kidney Trouble
___Buzzing/Ringing in ears
___Depression
___Sleeping Problems
___Bed Wetting
___Shortness of Breath
___Light Bothers Eyes
___PMS
___Cancer (Type)_____

___Neck Stiffness/ Pain
___Frequent Colds / Flu
___Skin Problems
___Blurred Vision R / L
___Lung Problems
___Gall Bladder Problems
___Loss of Smell
___Sinus Problems
___ Allergies
___ Irritability/Mood Swings
___ Cold Hands
___ Recurring Infection
___ Hot Flashes
___ Problems Urinating
___ Menopause
___ Numbness, Tingling, Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L

___Back Stiffness/Pain
___Diabetes
___Cancer
___Double Vision R/ L
___Loss of Taste
___Digestive Problems
___Loss of Balance
___Nervousness/Anxiety
___Tension/Stress
___Stomach Upset
___Diarrhea/Constip./Gas
___Jaw/TMJ Problems
___Heartburn/Reflux
___Ulcers

Additional Explanation: _____

Have you ever been to a chiropractor before? Y / N If YES, Name of Chiropractor and location_____
_____

CURRENT HEALTH CONDITION

Reason for today's visit _____

_____

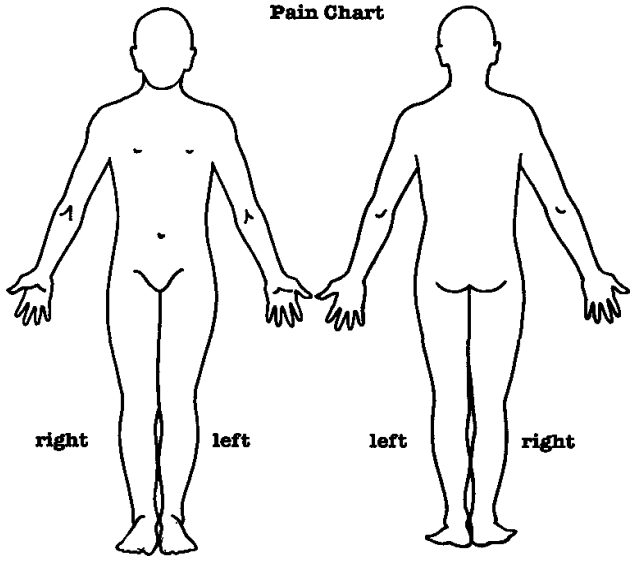
When did you first notice this problem?_____

Have you had this problem before? _____No _____Yes

What treatment have you already received for your condition?
___Medication ___Surgery ___Physical Therapy

Other_____

On the diagram to the right, mark the area of your complaints.



DAILY ACTIVITIES DISCOMFORT: Effects of Current Condition on Performance

Walking	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Sitting	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Bending	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Standing	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Sleeping	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Lifting	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Running/Jogging	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Climbing Stairs	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable

Please list any effects that this may have on any recreational activities:_____
_____

Are there any other complaints/conditions that the doctor should address? If so, list and describe_____
_____
_____

What medications are you currently taking and for what conditions? (prescription and OTC)_____
_____

What is your objective in coming to our office? □ Family Wellness Care □ Spinal health □ Symptom relief

What treatments have you attempted to solve this problem?_____
Have you been treated by a physician for any health condition in the past year? Y / N Reason? _____
Are you currently under the care of any other physician? Y / N Date of last physical exam _____
Family Dr's Name/Location? _____
On a scale of 1-10 (ten being the highest), rate your commitment to correcting the problem?_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

_____ _____/_____/_____

Signature Date

INSURANCE INFORMATION

Do you have health insurance? Yes/No

Insurance Co._____ Policy# _____

Insured's Name _____ Insured's Date of Birth _____/_____/_____

Winnsboro Chiropractic Clinic will make every effort to verify your Chiropractic insurance benefits and explain them to you within your first two visits. However, as your insurance policy is a contract between you and your insurer, we strongly advise you to call and personally confirm your benefits.

Terms of Acceptance

Winnsboro Chiropractic Clinic
Winnsboro, TX
Financial Policy

1) We accept cash, check, and credit/debit cards (Visa, MasterCard) payments at this time.

2) All payments are due at the time of service unless special arrangements have been agreed upon prior to your visit.

3) If you have Medicare, after your deductible is met, your co-pay and any non-covered services will be due at the time of service.

4) As a courtesy to our patients, we offer electronic claims submission. Please notify the staff if you wish to utilize this service.

Workers Compensation Claims
5) All workers compensation cases are treated same as cash.

Personal Injury/Motor Vehicle Accidents
6) Personal injury and auto accident cases are treated same as cash. We will provide you with the necessary documentation to file with your insurance company to facilitate your reimbursement.

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.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider 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 in my medical status.

I have read, understand and agree with the above financial policy.

_____ _____/_____/_____
Signature Date