# WELCOME

## *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.*

(Please Print)

Name: ______________________________________________ Date: ____________
First Middle Initial Last

Birthday: _____/_____/________ ❑ Female ❑ Male

Address: ______________________________________________ Apt #: ____________

City: ______________________________________________ State: ______ Zip: ____________

Home Phone: (_____)__________________ Work Phone: (_____)__________________

Cell Phone: (_____)__________________ Email: ______________________________

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Employer Name: ______________________________ Occupation: ____________________

Employer Address: ______________________________________________

City: ______________________________________________ State: ______ Zip: ____________

Parent/Guardian Name (if patient is minor): ______________________________

Person to Contact In Case of Emergency: ______________________ Phone: (_____)____________

Whom may we thank for referring you to us? ______________________________

## *Insurance Information*

Name of Insured: ______________________________________________

Insured's Birthday: _____/_____/________ Relationship to Patient: ____________________

Insured's Employer: ______________________________________________

Insurance Co.: ______________________________ Phone: (_____)____________

ID/Claim #: ______________________________ Group/Acct #: ____________________

LIST ADDITIONAL INSURANCE:

Name of Insured: ______________________________________________

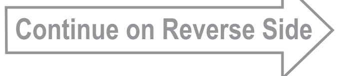
Insured's Birthday: _____/_____/________ Relationship to Patient: ____________________

Insured's Employer: ______________________________________________

Insurance Co.: ______________________________ Phone: (_____)____________

ID/Claim #: ______________________________ Group/Acct #: ____________________

CONFIDENTIAL


Continue on Reverse Side

## Symptoms

List your main issue: ______________________________

When did you first notice this issue? ______________________________

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Pain is constant ❑ Pain comes and goes

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down

Type of Pain: ❑ Sharp ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Dull
❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other ______________________________

Rate the severity of your pain (1 – mild pain or discomfort to 10 – severe pain): 1 2 3 4 5 6 7 8 9 10

What treatments have you already received for the condition? ❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other ______________

Name and address of other doctor(s) who have treated you for your condition:

______________________________

Other issues of concern: ______________________________

## Health History

*Check only those conditions which you have had:*

| | | | | |
|---|---|---|---|---|
| ❑ AIDS/HIV | ❑ Cataracts | ❑ Hepatitis | ❑ Osteoporosis | ❑ Suicide Attempt |
| ❑ Alcoholism | ❑ Chemical Dependency | ❑ Hernia | ❑ Pacemaker | ❑ Thyroid Problems |
| ❑ Allergy shots | ❑ Chicken Pox | ❑ Herniated Disc | ❑ Parkinson's Disease | ❑ Tonsillitis |
| ❑ Anemia | ❑ Depression | ❑ Herpes | ❑ Pinched Nerve | ❑ Tuberculosis |
| ❑ Anorexia | ❑ Diabetes | ❑ High Cholesterol | ❑ Pneumonia | ❑ Tumors, Growths |
| ❑ Appendicitis | ❑ Emphysema | ❑ Kidney Disease | ❑ Polio | ❑ Typhoid Fever |
| ❑ Arthritis | ❑ Epilepsy | ❑ Liver Disease | ❑ Prostate Problems | ❑ Ulcers |
| ❑ Asthma | ❑ Fractures | ❑ Measles | ❑ Prosthesis | ❑ Vaginal Infections |
| ❑ Bleeding Disorders | ❑ Glaucoma | ❑ Migraine Headaches | ❑ Psychiatric Care | ❑ Venereal Disease |
| ❑ Breast Lump | ❑ Goiter | ❑ Miscarriage | ❑ Rheumatoid Arthritis | ❑ Whooping Cough |
| ❑ Bronchitis | ❑ Gonorrhea | ❑ Mononucleosis | ❑ Rheumatic Fever | ❑ Other __________ |
| ❑ Bulimia | ❑ Gout | ❑ Multiple Sclerosis | ❑ Scarlet Fever | __________ |
| ❑ Cancer | ❑ Heart Disease | ❑ Mumps | ❑ Stroke | __________ |

Date of last exam? ______________________________

List any types of surgeries which you have had and the dates which they occurred:

______________________________

Please list all medications you are currently taking: ______________________________

Allergies: ______________________________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

## Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (Example: sitting, standing, light labor, heavy labor, computer work)

______________________________

What vitamins/supplements do you current take? ______________________________

Do you smoke? ❑ No ❑ Yes If yes, how much per day? ______________________________

How much liquor do you consume on a weekly basis? ______________________________

How much coffee or caffeinated beverages do you consume on a daily basis? ______________________________

## Consent, Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to information my doctor if I, or my minor child, ever have a change in health. I consent to chiropractic treatment at Amesbarry Chiropractic.

I certify that I, and/or my dependent(s), has insurance coverage I authorize assignment ______________________________
Name of Insurance Company(ies)

and assign directly to ***Amesbarry Chiropractic*** all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient