SUNRISE
HEALTH INSTITUTE

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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Please circle best number to call: Home Cell Work**
Email address:	**Social Security Number:**
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Names of children: **Ages of children:**	
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? **Yes ☐ No ☐**	**Do you have Medicare coverage?** **Yes ☐ No ☐**
Have you ever seen a chiropractor before? **Yes ☐ No ☐**	**Approximate date of last visit ___/___/___**
Previous Chiropractor's Name/City/State:	**Did you see the results you hoped to? Yes ☐ No ☐**
Please check if you are here for any of the following: Motor Vehicle Injury ☐ Work Injury ☐ Other Injury ☐	
Please allow us to make a copy of your insurance card.	

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

What is the reason for your visit today?

_____

_____

Are there any other specific concerns?

_____

_____

How You Got to Where You Are Now

Are there any specific physical, chemical or emotional stresses you are aware of that your mother endured while she was pregnant with you? These could include any accident or injury, unhealthy diet or exposure to harmful substances, or any emotionally stressful event during the pregnancy. **Yes** ☐ **No** ☐

Please explain

_____
_____

1) When you were a baby/toddler, (birth to 4 years), did any of the following occur?

__Fall from Changing Table
__Tumble down stairs
__Fall out of crib
__Involved in car accident
__Fall off playground equipment
__Play in a "Jolly Jumper"
__Tonsillitis
__Reaction to vaccination
__Frequent crying spells
__Frequent fevers
__Frequent bouts of diarrhea
__Constipation
__Sleeping Problems
__Frequent colds
__Colic
__Did not gain weight
__Other_____

Please explain the above_____
_____

2) When you were a young child, (5-12), did any of the following occur?

__Fall from a tree
__Fall off bicycle
__Fall off playground equipment
__Sports accident
__Car accident
__Stomach pains
__Scoliosis
__Bed wetting
__Hyperactivity/Autism
__Learning difficulties
__Asthma
__Allergies
__Leg/knee pain
__Other_____

Please explain the above_____
_____

3) When you were a child or adolescent, (13-17), did any of these occur?

__Headaches
__Dizziness
__Asthma
__Hyperactivity
__Fatigue
__Attention/focus/concentration issues
__Sleeping problems
__Weight gain/loss
__Foot/ankle/knee pains
__Tingling in arms/legs
__Numbness in arms/hands
__Arm/wrist pains
__Neck/back pains
__Shoulder pains
__Other_____

Please explain the above_____
_____

Which Direction Are You Headed?

Will you be as happy and healthy as you are today (or BETTER) in 5 years? **Yes** ☐ **No** ☐ **Not Sure** ☐

If yes, what will you do to make sure you are healthier? (drink more water, better nutrition, exercise, etc.)

_____

_____

If no or not sure, what could you do to start getting happier and healthier?

_____

_____

How committed are you to actively participating in moving yourself towards greater levels of happiness, peace, excitement, health, wellness and wholeness? (Please circle your answer below)

Not at all 1 2 3 4 5 6 7 8 9 10 100% Committed

Past Health History

Please mark the following conditions you may have had or have now (- have had, + have now):

☐ Allergy	☐ Anemia	☐ Ankle/ Foot Pain	☐ Arm/ Wrist Pain	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Calcification of the Arteries	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions
☐ Depression	☐ Diabetes	☐ Diarrhea	☐ Dizziness	☐ Eczema	☐ Emphysema
☐ Epilepsy	☐ Fatigue	☐ Gall Bladder Problems	☐ Gout	☐ Headaches	☐Heart Attack
☐ Heart Disease	☐ High Blood Pressure	☐ Hyperactivity	☐ Irregular Periods	☐ Low Blood Sugar	☐ Menstrual Cramps
☐ Migraines	☐ Miscarriage	☐ Multiple Sclerosis	☐ Neck Pain	☐ Nerve Pain	☐ Nervousness
☐ Numbness in Arms/ Hands	☐ Pneumonia	☐ Polio	☐ Ringing in Ears	☐ Shoulder Pain	☐ Sinus Problems
☐ Sleeping Issues	☐ Stroke	☐ Thyroid Problems	☐ Tuberculosis	☐ Ulcers	☐ Weight gain/loss

Current Medicines and Supplements

Please list any medications, supplements, or vitamins that you are currently taking and why:

Date	Name of Medication, Vitamin, or Supplement	Dosage	Dose Schedule	Reason for Taking

Is there anything else you would like for the doctor know?

_____

_____

Our Fee Structure

Consultation	Complimentary
Examination	$ 100.00
(Includes computerized neurospinal evaluation)	
Infant Exam	$ 40.00

Please Note: If you and the doctor decide this is the place for you to be, then you will receive an adjustment on your first visit which will be an additional fee. Your clinical Report of Findings, the time that the doctor will spend with you to go over your results, will be included with your examination. You will receive an adjustment after your Report of Findings that will be a separate fee.

Insurance and Payment Policy

We are committed to providing you with the best possible care. If you have Chiropractic coverage in your insurance policy, we are willing to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment Policy:

1. Full payment is due at time of service. We accept cash, checks, Visa, MasterCard and Discover.
2. We must emphasize that our relationship is with you and not your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract and therefore do not file your insurance for you. As a courtesy that we extend to our patients, we will provide you with a completed insurance form; however, you are responsible for filing it, which simply means placing it in an envelope and mailing it.
3. Not all services are a covered benefit in all contracts. It will depend on your individual policy.
4. In most cases, once you have met your deductible your insurance company will begin to reimburse you up to an allowed amount. If you have a question about your specific policy and coverage, please call the toll free number on the back of your insurance card and they should be able to answer your questions regarding your policy.
5. Medicare patients are responsible for payment at the time of service because Medicare does not cover chiropractic in this office. We will not file claims to Medicare. Medicare patients will sign an Advanced Beneficiary Notice of Noncoverage stating that they understand this and they would still like to receive services.

There is no fee for consulting with the doctor. Fees begin when a problem related to nerve interference is found and you decide to begin receiving care.

_____***I fully understand the above fees and give my consent to consult with the doctor and to any computerized neurospinal examination that the doctor deems necessary. I understand that any fee for service is due at the time of service and cannot be deferred to a later date.***

Print Patient Name: _____ Date: _____

Signature: _____
(Signature of Parent/Guardian required if patient under age 18)

We sincerely thank you for choosing our office and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!