WELCOME!

Pt. No._____

Thank you for choosing O'Brien Chiropractic for your chiropractic health care. As you complete this form don't hesitate to ask any questions or ask for assistance. We will be happy to help you.

Patient Information:

Name_____Date_____ SS_____-_____-_____

Address_____City_____Zip_____

Female____Male_____Birth date_____ No. Of Children_____Referred by_____

Home phone_____Work phone_____Cell Phone_____

Insurance Information:

Insurance Company_____Subscriber name_____Subscribers birth date_____

Are you: (circle one) Minor Married Divorced Widowed Single

Your employer_____Occupation_____

Business address_____City_____Zip_____

Spouse or parent's name_____Workplace_____Phone_____

Have you received chiropractic care in the past?_____Name and city of that doctor_____

Person to contact in case of emergency_____Phone_____

Responsible Party:

Name of person responsible for this account_____Relationship_____

Address_____Phone_____

Symptoms:

Reason your visit_____Is Condition due to Job/Auto Accident_____

When did you first notice the symptoms?_____Is it getting progressively worse?_____

Health History:
What treatment have you already received for this condition? Check all that may apply.

Chiropractic_____Medication_____Surgery_____Physical Therapy_____Other_____

Height_____ Weight_____Name and city of your family doctor_____

Check any of the following conditions which you have had in the past year.
Alcoholism Allergies Anemia Arthritis Asthma Bronchitis Cancer Chemical dependancy Depression Diabetes Epilepsy Emphysema Fractures Heart Disease Hernia Herniated Disc Kidney disease Liver Disease Migraine Headaches Multiple Sclerosis Osteoporosis Pacemaker Parkinson's disease Pinched nerve Pneumonia Polio Rheumatoid Arthritis Stroke Thyroid problems Ulcers Other_____

List any family members which may have had any of the above mentioned conditions.
Father_____Mother_____Brother_____Sister_____Spouse_____Child_____

Date of last physical_____ (Women) Are you pregnant?_____Due date_____Nursing?_____

List surgeries you have had and the date they occurred_____

Please list medications you are taking_____

Please list nutritional supplements you are taking_____

Daily Habits:

What type of exercise do you perform on a daily basis?_____

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

_____

Do you smoke?____ How much per day?_____How much liquor do you consume on a daily basis?_____

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

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and / or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature_____Date_____
(Or parent if a minor)