Welcome to Maggiore Chiropractic

Name _____ Date _____ Birth Date _____ Gender M F

Address_____ City, State, Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____ Employer _____

Race (circle) Caucasian African-American Hispanic Asian American Indian Other _____

E-mail address _____ Preferred method of reminders: Phone / E-mail / Mail

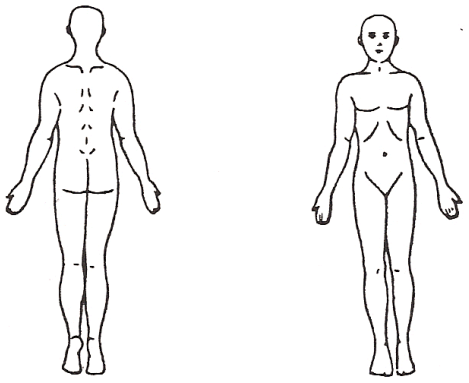
Marital Status: S M W D Name of Spouse/Significant other _____

Spouse's/ Sig. Other's Occupation _____ Employer _____

In case of emergency, contact _____ Phone number _____

Whom may we thank for referring you? _____

Please indicate on the figure BELOW the areas of pain, numbness, weakness, etc.:



How long ago did it start? _____

On a scale of 1 to 10 with 10 being the worst what would you rate it (ok to use a range of numbers)? _____

Does the pain come and go? Y / N

How often is it present? _____

What makes it worse? _____

What makes it better? _____

Any prior surgeries? Y / N Describe: _____

Smoking History (circle one): Never Smoked Former smoker Every Day Smoker

Please check the circle if you **recently** have had any of the following symptoms:

- ○ Dizziness
- ○ Headaches
- ○ Digestive Disorders
- ○ Blurry vision
- ○ Nausea
- ○ Menstrual Problems
- ○ Sleep Apnea
- ○ Nervousness

Please check the circle if you have **ever** have had the following:

- ○ Heart Trouble
- ○ Diabetes
- ○ Herniated disc
- ○ Kidney disorders
- ○ Arthritis
- ○ Thyroid disorder
- ○ Asthma
- ○ Neuropathy
- ○ Stroke
- ○ Cancer

Please continue to the back of this sheet

Are you currently taking any medications?

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Any allergies to medications? Y / N Describe: _____

Family History

Family Member	Health Problem(s) if any
Father	
Mother	
Siblings or Children	

Would you like an e-mail sent to you of your clinical summary after each visit? *(Most patients select **NO** since the e-mail only lists an appointment as your visit summary.)* ☐**No** ☐**Yes**

We can send an appointment reminder to you by Text Message. If you would like us to use this, then please write your cell phone service provider _____

Insurance Information

Name of person responsible for payment: _____

Are you insured? Yes/ No Company: _____

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that C. Dax Maggiore, DC, PA will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to C. Dax Maggiore, DC, PA (aka Maggiore Chiropractic) will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's (or Guardian's) signature _____ **Date** _____