



Welcome

Tell us about you:

Today's date: ___/___/___ File #: _____

Patient name: _____
LAST FIRST MI

What do you prefer to be called: _____

(√)Male: ___ Female: ___ Birthdate: ___/___/___

Age: _____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ EXT. _____

Other Phone #'s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

(√)Status: ___ Minor ___ Single ___ Married

___ Divorced ___ Separated ___ Widowed

Spouse's Name: _____

Do you have children? ___ Yes ___ No #: _____

Insurance info:

Co. name: _____

Address: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____

Insured's Employer: _____

2nd Insurance info:

Co. name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____

Insured's Employer: _____

Reason For Visit:

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma, chronic
(*Explain what happened*): _____

Please describe the pain & its location: _____

When did the condition begin? ___/___/___

Is this condition getting worse? ___ Yes ___ No ___ Constant ___ Comes and goes

Is this condition interfering with your (*Please circle*): work, sleep, or daily routine

If so, please explain: _____

Have you had this or similar conditions in the past? ___ Yes ___ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition: ___ Yes ___ No

If so, where?: _____

Have you been treated by a Chiropractor for this condition: ___ Yes ___ No

If so, whom?: _____ Phone#: _____

Health History:

(√) Are you taking any of the following medications?

___Anti-Dpressants ___Pain Killers (including aspirin) ___Muscle Relaxers ___Stimulants
___ Blood Thinners ___Tranquilizers ___Insulin ___Other(s): _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart attack/ Stroke	Y N Heart Surg./ Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/ Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV +/- AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/ Glaucoma	Y N Anemia
Y N High/ Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/ Frequent Headaches	Y N Kidney Problems	Y N Ulcers/ Colitis
Y N Fainting/ Seizures/ Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes /Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/ Joints	Y N Arthritis

Please list any other serious medical condition(s) you may have or ever had:

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

Do You: Take supplements or vitamins? ___Yes ___No / Exercise? ___Yes ___No

Are you in a special diet? ___Yes ___No / Since: ___/___/___

Do you smoke? ___Yes ___No ? How much? _____ How long? _____

Are you wearing: ___Heel Lifts ___Sole Lifts ___Inner Soles ___Arch Supports

What is the age of your mattress? _____ Is it comfortable? ___Yes ___No

For Women: Are you taking any birth control? ___Yes ___No

Are you pregnant? ___Yes ___No / How Long? ___/___ / Nursing? ___Yes ___No

In Event of Emergency:

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your family physician? _____ Phone #: _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the Doctor and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of the service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process the 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 to the info. I have provided.



Account Info:

Person Ultimately Responsible for the account.

Name: _____

Relation: _____

Billing Address : _____

CITY STATE ZIP

SSN: _____

D.L. #: _____

Work Phone #: _____

Payment Method: ___Cash___ Check

_____/_____/_____

___Credit Card – Enter # above

_____ I hereby authorize assignment of my
initial insurance rights and benefits directly to the
provider for services rendered. I fully understand
I am solely responsible for any balance not paid
by my insurance company(if offered at this office).

_____ Date ___/___/___

Signature