WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease."
- Thomas Edison

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	SEX: ☐ MALE ☐ FEMALE	TODAY'S DATE:
SOCIAL SECURITY #:	DATE OF BIRTH:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW	
HOME ADDRESS:	CITY:	STATE, ZIP:	
HOME PHONE:	CELL PHONE:	BUSINESS PHONE:	
OCCUPATION:	EMPLOYER:	WHOM MAY WE THANK FOR REFERRING YOU TO US?	
IN CASE OF EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:	

PRIVATE INSURANCE (Include copy of insurance card, front and back)

PRIMARY INSURANCE COMPANY NAME:		PHONE:
PRIMARY INSURANCE COMPANY ADDRESS:	CITY:	STATE, ZIP:
INSURANCE ID #:	GROUP #:	CERTIFICATE #:
SECONDARY INSURANCE COMPANY NAME:		PHONE:
SECONDARY INSURANCE COMPANY ADDRESS:	CITY:	STATE, ZIP:

INSURED INFORMATION (If other than patient)

LAST NAME:	FIRST NAME:	PHONE:
SOCIAL SECURITY #:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:

HEALTH HISTORY (check only those conditions which are applicable)

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES/MEDICAL CONDITION(s)?

☐ YES ☐ NO	Heart attack / stroke	☐ YES ☐ NO	Heart Surgery /Pacemaker	☐ YES ☐ NO	Heart Murmur
☐ YES ☐ NO	Congenital heart disease	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Artificial Valves
☐ YES ☐ NO	Alcohol / drug abuse	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO	Hepatitis
☐ YES ☐ NO	HIV – Aids	☐ YES ☐ NO	Shingles	☐ YES ☐ NO	Cancer
☐ YES ☐ NO	Frequent neck pain	☐ YES ☐ NO	Emphysema / Glaucoma	☐ YES ☐ NO	Anemia
☐ YES ☐ NO	High / low blood pressure	☐ YES ☐ NO	Psychiatric Problems	☐ YES ☐ NO	Rheumatic Fever
☐ YES ☐ NO	Severe / frequent headaches	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Ulcers / Colitis
☐ YES ☐ NO	Fainting / seizures / epilepsy	☐ YES ☐ NO	Sinus Problems	☐ YES ☐ NO	Asthma
☐ YES ☐ NO	Diabetes / tuberculosis	☐ YES ☐ NO	Difficulty Breathing	☐ YES ☐ NO	Chemotherapy
☐ YES ☐ NO	Lower back problems	☐ YES ☐ NO	Artificial Bones /Joints	☐ YES ☐ NO	Arthritis

DATE OF LAST MEDICAL EXAM:	LIST ANY TYPES OF SURGERIES WHICH YOU HAVE HAD AND THE DATES WHICH THEY OCCURRED	
LIST ANY MEDICATIONS YOU ARE TAKING:	LIST ANY ALLERGIES YOU HAVE:	LIST ANY PAST ACCIDENTS WITH DATES:
FAMILY HEALTH HISTORY:		

REASON FOR VISIT

HAVE YOU EVER BEEN TREATED BY A CHIRO BEFORE?	IF SO, PLEASE EXPLAIN:
☐ YES ☐ NO	

THE REASON FOR THIS VISIT IS A RESULT OF (circle):	WHEN DID CONDITION BEGIN:	IS THIS CONDITION GETTING WORSE?
☐ WORK ☐ SPORTS ☐ AUTO ☐ TRAUMA ☐ CHRONIC		☐ YES ☐ NO ☐ CONSTANT ☐ COMES & GOES

PLEASE DESCRIBE THE PAIN:

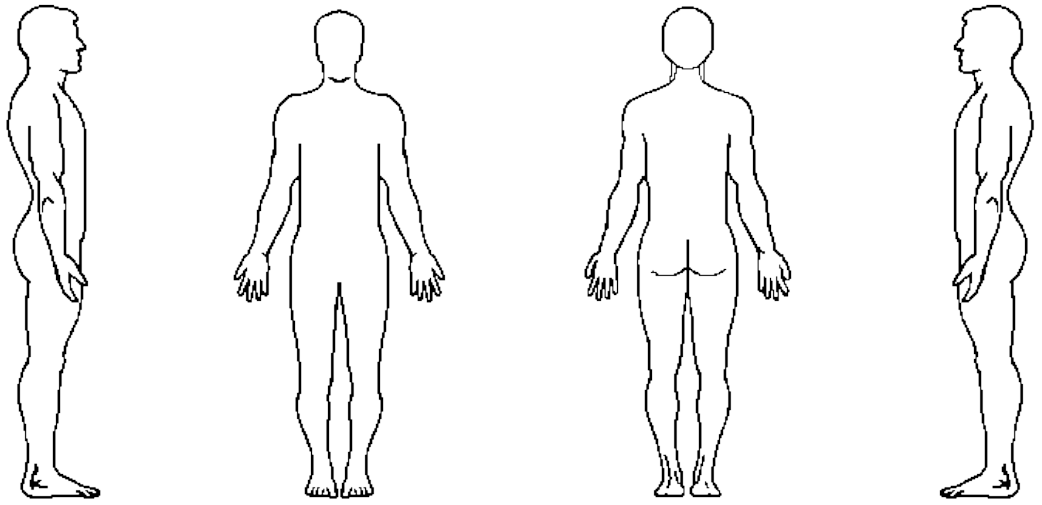
IS THIS CONDITION INTERFERING WITH YOUR (circle):	IF SO, PLEASE EXPLAIN:
☐ WORK ☐ SLEEP ☐ DAILY ROUTINE	

HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST?	IF SO, PLEASE EXPLAIN:
☐ YES ☐ NO	

HAVE YOU EVER BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS CONDITION?	IF YES, WHEN AND WHERE?
☐ YES ☐ NO	

PLEASE MARK AREA (S) OF INJURY OR DISCOMFORT:

N = NUMBNESS T = TINGLING / PINS & NEEDLES P = PAIN / ACHES & SORENESS



LEFT FRONT BACK RIGHT

RATE YOUR PAIN (1 = mild, 10 = severe)

1 2 3 4 5 6 7 8 9 10

DAILY HABITS

WHAT TYPE OF EXERCISE DO YOU PERFORM ON A DAILY BASIS?	WHAT DO YOUR DAILY HABITS INCLUDE? (sitting, standing, light /heavy labor, computer, etc.):
☐ NONE ☐ MODERATE ☐ HEAVY	

ARE YOU WEARING	DO YOU SMOKE? IF YES, HOW MUCH PER DAY?
☐ HEEL LIFTS ☐ SOUL LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS	☐ YES ☐ NO

HOW MUCH LIQUOR DO YOU CONSUME ON A WEEKLY BASIS?	HOW MANY CAFFEINATED BEVERAGES DO YOU COMSUME 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 me, or my child, 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 dependents. If appointments are not canceled within 24 hours, patient will be charge for visit.

SIGNATURE OF PATIENT (OR PARENT OF A MINOR) DATE

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