

1
one

WELCOME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
LAST FIRST MI

What 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 How many? _____

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two

INSURANCE INFO

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did 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 ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone#: _____

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three

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact?
Relation:
Home Phone #: Work Phone #:
Who is your Medical Doctor? Phone #:

HEALTH HISTORY

Are you taking any of the following medications?

Checkboxes for Nerve pills, Pain killers, Muscle relaxers, Stimulants, Blood Thinners, Tranquilizers, Insulin, Other(s)

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

Grid of checkboxes for various conditions: Heart Attack, Congenital Heart Defect, Alcohol/Drug Abuse, HIV+, Frequent Neck Pain, High/Low Blood Pressure, Severe/Frequent Headaches, Fainting/Seizures/Epilepsy, Diabetes/Tuberculosis, Lower Back Problems, Heart Surg./Pacemaker, Mitral Valve Prolapse, Venereal Disease, Shingles, Emphysema/Glaucoma, Psychiatric Problems, Kidney Problems, Sinus Problems, Difficulty Breathing, Artificial Bones/Joints, Heart Murmur, Artificial Valves, Hepatitis, Cancer, Anemia, Rheumatic Fever, Ulcers/Colitis, Asthma, Chemotherapy, Arthritis

Please list any other serious medical condition(s) you 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? Exercise? Yes/No

Are you on a special diet: Yes/No / Since: / /

Do you smoke? No/Yes / 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 Birth Control? Yes/No

Are you Pregnant? No/Yes/How long? Nursing? Yes/No

five

six

ACCOUNT INFO

Person ultimately responsible for account

Name:

Relation:

Billing Address:

CITY STATE ZIP

SSN:

D.L.#:

Work Phone#:

Payment method: CASH Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my 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).



PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider 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.
I authorize the staff to perform any necessary services needed during diagnosis and treatment.
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 information I have provided.

Signature Date / /

Adult Patient Parent or Guardian Spouse

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Please describe your condition:

Signature: _____ Date: ____ / ____ / ____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness
Symbol → NNNN

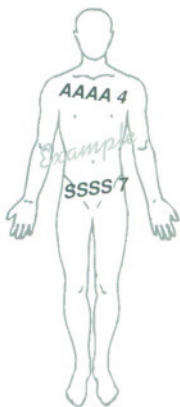
Pins & Needles
PPPP

Burning
BBBB

Aching
AAAA

Stabbing
SSSS

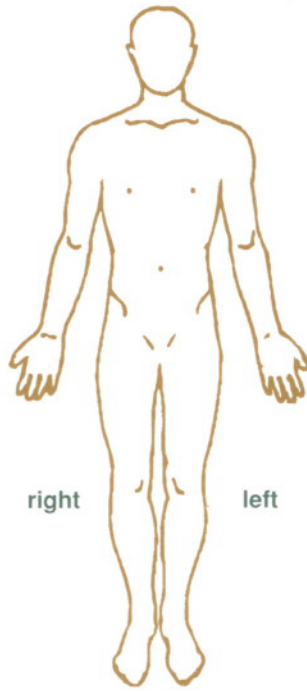
○ Circle any area of pain not represented by a symbol.



Example



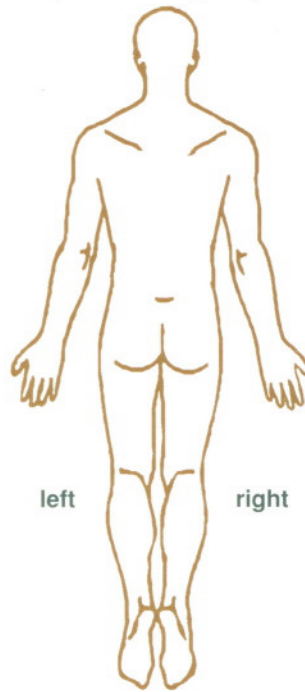
Right



right

left

Front



left

right

Back



Left

DOCTOR'S NOTES

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET 