

### About the Patient

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Gender  M  F Number of Children \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Type of Work \_\_\_\_\_  
 Marital Status  Married  Single  Divorced  
 Separated  Widowed  
 Email Address \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Payment Method  Cash  Check  Credit  
 Card CC# \_\_\_\_\_ Exp: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Reason For This Visit

Describe the purpose of this visit: \_\_\_\_\_  
 \_\_\_\_\_  
 Is the purpose of this appointment related to:  
 Job  Sports  Auto  Fall  
 Chronic Discomfort  Home Injury  Other  
 Please explain \_\_\_\_\_  
 If job related, have you made a report of your accident to your employer?  Yes  No  
 When did this condition begin? \_\_\_\_\_  
 Has this condition  gotten worse  stayed constant  
 comes and goes  
 Does this condition interfere with  
 work  sleep  Daily Routine  Other activities  
 Please explain \_\_\_\_\_  
 Has this condition occurred before?  Yes  No  
 Explain \_\_\_\_\_  
 Have you seen other doctors for this condition?  
 Yes  No  
 Dr.'s Name (s) \_\_\_\_\_  
 Type of Treatment \_\_\_\_\_  
 Results \_\_\_\_\_

### About the Spouse or Parent

Name \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Type of Work \_\_\_\_\_

### Experience With Chiropractic

Who referred you to this office? \_\_\_\_\_  
 Have you been adjusted by a Chiropractor before?  Yes  No  
 Reason for those visits? \_\_\_\_\_  
 Doctor's Name \_\_\_\_\_  
 Approximate date of last visit? \_\_\_\_\_  
 Has any *adult* in your family seen a Chiropractor?  Yes  No  
 Has any *child* in your family seen a Chiropractor?  Yes  No

### Awareness of Chiropractic Principles

Were you aware that...  
 Doctors of Chiropractic work with the nervous system?  Yes  No  
 The nervous system controls all bodily functions and systems?  Yes  No  
 Chiropractic is the largest natural healing profession in the world?  Yes  No  
 If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?  Yes  No

## Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care:** Symptomatic relief of pain or discomfort
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care appropriate for my condition.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## Medications I Now Take

- |  |   |
|--|---|
| <input type="checkbox"/> Nerve Pills                       | <input type="checkbox"/> Stimulants     |
| <input type="checkbox"/> Pain Killers (including Aspirins) | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Muscle Relaxers                   | <input type="checkbox"/> Tranquilizers  |
| <input type="checkbox"/> Blood Pressure Medicine           | <input type="checkbox"/> _____          |
| <input type="checkbox"/> Insulin                           | <input type="checkbox"/> _____          |

## Health Habits

- |                            | No                                   | Yes                                    |
|----------------------------|--------------------------------------|--|
| Do you smoke?              | <input type="checkbox"/>             | <input type="checkbox"/>               |
| Do you drink alcohol?      | <input type="checkbox"/>             | <input type="checkbox"/>               |
| Do you drink coffee?       | <input type="checkbox"/>             | <input type="checkbox"/>               |
| Do you exercise regularly? | <input type="checkbox"/> No          | <input type="checkbox"/> Moderate      |
|                            | <input type="checkbox"/> Daily       |  |
| Do you wear                | <input type="checkbox"/> Heel Lifts  | <input type="checkbox"/> Sole lifts    |
|                            | <input type="checkbox"/> Inner Soles | <input type="checkbox"/> Arch Supports |

## HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- |   |   |
|---|---|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Congenital Heart Detect  |
| <input type="checkbox"/> Sinus Problems               | <input type="checkbox"/> Heart Surgery/ Pacemaker |
| <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> High/low Blood Pressure  |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Psychiatric Problems     |
| <input type="checkbox"/> Loss of Sleep                | <input type="checkbox"/> Difficulty Breathing     |
| <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Pain Between the Shoulders   | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> Frequent Neck Pain           | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Numbness or Pain in          | <input type="checkbox"/> Alcohol/Drug Abuse       |
| <input type="checkbox"/> Arms/Legs/Hands              | <input type="checkbox"/> Venereal Disease         |
| <input type="checkbox"/> Lower Back Problems          | <input type="checkbox"/> HIV/AIDS                 |
| <input type="checkbox"/> Digestive Problems           | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Ulcers/Colitis               | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Heart Attack/Stroke          | <input type="checkbox"/> Shingles                 |
| <input type="checkbox"/> Thyroid Problems             | <input type="checkbox"/> Chemotherapy             |
| <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Anemia                   |

### FOR WOMEN ONLY:

- Are you pregnant?  
 Yes  No
- Are you nursing?  
 Yes  No
- Are you taking birth control?  
 Yes  No
- Do you experience painful periods?  
 Yes  No
- Do you have irregular cycles?  
 Yes  No
- Do you have breast implants?  
 Yes  No

## AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian or Spouse's Signature

\_\_\_\_\_  
Date

### Who should receive bills for payment on your account?

- Patient     Spouse     Parent     Worker's Comp.  
 Medicare     Personal Health Insurance     Auto Insurance

### Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

## Emergency Contact

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

## My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Group # \_\_\_\_\_

Phone Number \_\_\_\_\_

### ABOUT THE INSURED PERSON

Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_