

Name _____ SS # _____ Home Phone _____

Address _____ City _____ State _____ ZIP _____

Email address _____ Cell Phone _____

Age ____ Birth Date _____ Male ____ Female ____ Marital: M S W D No. of Kids? _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Insured' name if patient is a dependent _____ SS# _____

Name of Wife or Husband _____ DOB _____

Occupation _____ Employer _____ Address _____

Emergency

Contact _____ Address _____ Phone _____

How did you hear about us? _____

Is condition due to injury or sickness arising out of patient's employment? _____

Date symptoms appeared or accident happened? _____

Patient ever had same or similar condition: Yes ____ No ____ If yes, when and describe _____

Have you lost any days from work? _____

Have You Ever Suffered From:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Spinal curvatures | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Kidney infection or stone |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> Nervousness/ Depression | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cramps or backache |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Excessive menstrual flow |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nausea | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Colds | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Deafness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tingling or numbness in: | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Difficult breathing | |
| <input type="checkbox"/> Hips | <input type="checkbox"/> Failing vision | <input type="checkbox"/> Pleurisy | |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Spitting | |
| <input type="checkbox"/> Legs | | <input type="checkbox"/> Swelling of ankles | |
| <input type="checkbox"/> Elbows | | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Knees | | | |
| <input type="checkbox"/> Feet | | | |

HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____

DO YOU:
 Now take Vitamins or minerals? Yes _____ No _____
 Think you may need vitamins or minerals? Yes _____ No _____
 Are you wearing: Heel lifts _____ Sole lifts _____

Date of last physical examination: _____ Female: Are you pregnant? _____ Due Date _____

What operations have you had? _____

Serious illnesses? _____ Fractured bones? _____

Have you ever been under Chiropractic Care? Yes _____ No _____ Doctor's Name _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes _____ No _____ Constant _____ Comes & Go _____

Is this condition interfering with your: Work _____ Sleep _____ Daily routine _____ Other _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Other doctor seen for this condition _____

Have you been treated for any health conditions by a physician in the last year? Yes _____ No _____

Describe _____

What medications or drugs are you taking? _____

Family doctor's name _____ Clinic _____

Send a report? Yes _____ No _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of Person responsible for payment _____

Are You Insured? Yes _____ No _____ Company Name _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me 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 me will be immediately due and payable.

I will be paying today by: Cash _____ Check _____

Patient's Signature _____ Date _____

Guardian Name _____ Guardian

Signature _____

Information Taken by _____ Date _____

