

# WELCOME

### ABOUT YOU \_/\_\_\_\_ File #: \_\_\_ Today's Date: \_\_\_ Patient Name:\_ FIRST What You Prefer To Be Called: \_\_ ■ Male ■ Female Birthdate: \_\_\_/\_\_\_ / \_\_\_ Age:\_\_\_\_\_ SS#: \_\_\_ Mailing Address: \_\_\_ STATE CITY Home Phone #: \_\_\_ \_\_\_\_\_ Ext: Work Phone #: Other Phone #s: E-Mail Address: Referred By: \_\_\_ Employer: How Long? Employer's Address: \_\_\_ STATE CITY Occupation: Status: Minor Single Married Divorced Separated Widowed Spouse's Name: Do you have children? ☐ Yes ☐ No How many?

two

	NSURANCE	IN	IF0
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 desi			

REAJON OR VIJI				
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? $\ \square$ Yes $\ \square$ No $\ \square$ Constant $\ \square$ 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? $\square$ Yes $\square$ No				
If so, where?				
Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No				
If so, whom? Phone#:				



PLEASE CONTINUE ON BACK



# 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?							
□ Nerve pills □ 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 High/Low Blood Pressure Y N Severe/Frequent Headaches Y N Fainting/Seizures/Epilepsy Y N Diabetes / Tuberculosis Y N Lower Back Problems Please list any other serious	Y N Psychiatric Problems Y N Kidney Problems Y N Sinus Problems Y N Difficulty Breathing Y N Artificial Bones / Joints	Y N Rheumatic Fever Y N Ulcers / Colitis Y N Asthma Y N Chemotherapy Y N Arthritis					
Please list anything that you may be allergic to:							
List previous surgeries/treatments with dates:							
List any <b>past</b> serious accidents with dates:							
Family Health History:							
Do you: Take Supplements or Vitamins? ☐Yes ☐ No / 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							





### ACCOUNT INFO

	Person ultimately responsible for account
	Name:
	Relation:
	Billing Address:
	CITY STATE ZIP
	SSN:
	D.L.#:
eff	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).

- 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. If account is not paid within 90 days of the date of 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 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 information I have provided.

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Signature	Date / /	
☐ Adult Patient ☐ Parent or Guardian ☐ Spouse		