About You

Today's Date: ____/____/______

Patient Name: ____ **M / F (circle)**

First **MI** **Last**

Birth date ____/____/______ **Address:** ____

City **State** **Zip**

Home Phone: ____________ **Cell Phone:** ______________ **Work Phone:** ______________

Email Address: ________________________ **Referred By:** ________________________

Employer: ________________________ **Occupation:** ________________________

Marital Status: ________________________ **SS#** ________________________

Spouse's Name: ______________________________ **Spouse's Birth date:** ____/____/________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ________________________________ and assign directly to Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

____________________________ ____________________

Relationship **Date**

Is this your first visit to a Chiropractic Office?

☐ **Yes** ☐ **No**

Is your condition due to an accident injury?

☐ **Yes** ☐ **No**

If yes, did this occur:

☐ **At work**
☐ **In an automobile**
☐ **During sports**
☐ **Other**

PLEASE READ THE FOLLOWING AND SIGN AT THE BOTTOM:

I know that I am responsible for, and agree to pay all fees incurred at this office. I understand that any insurance benefits which I may have are a contracted arrangement between me and my insurance company. This office will be responsible for preparing notes, billing receipts and informational reports as needed to aid in insurance payment/reimbursement. I realize that this office is not responsible to negotiate disputed benefits for me.

I am choosing to be treated, for today and all my future visits at this office, through the use of various types of chiropractic manipulations, diagnostic x-rays and several types of physiologic modalities (physical therapy). I realize there is no guarantee of results, and have been informed that some risks of treatments do exist. These risks could include, but are not limited to: sprains, dislocations, fractures, strokes, and disc injury. While I do expect my doctor to use his/her best judgment to choose the most appropriate care for my condition, I agree that the doctor cannot foresee every possible complication or risk which could arise in my treatment.

My signature below signifies that I completely understand and agree to all of the above statements and give my consent for treatment.

______________________________ ____________________

Patient Signature **Date**

OVER→

Reason for Visit

Reason for today's visit:____

When did your symptoms appear?____

If you are experiencing pain, is it… ☐ Comes and goes ☐ Constant ☐ Traveling/Radiating

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramping ☐ Stiffness ☐ Swelling ☐ Other____

Since the problem started, it is… ☐ About the same ☐ Getting better ☐ Getting worse

Rate the severity of your pain on a scale from 1 (minimal) to 10 (severe):__________

It interferes with… ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Daily Routine ☐ Leisure

Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Bending ☐ Lying Down ☐ Walking

Other Doctors seen for this problem (please list)

☐ **Chiropractor**____

☐ **Medical Doctor**____

☐ **Other**____

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking…………… Packs/Day______________________
☐ Alcohol……………. Drinks/Week____________________
☐ Caffeine/Coffee…… Cups/Day______________________
☐ High Stress Level…. Reason________________________

Health History

Please mark Y (Yes) or N (No) to indicate if you have had any of the following:

Condition	Y/N	Condition	Y/N	Condition	Y/N	Condition	Y/N
AIDS/HIV	☐ Y ☐ N	**Emphysema**	☐ Y ☐ N	**Mono**	☐ Y ☐ N	**Scarlet Fever**	☐ Y ☐ N
Alcoholism	☐ Y ☐ N	**Epilepsy**	☐ Y ☐ N	**Multiple Sclerosis**	☐ Y ☐ N	**Stroke**	☐ Y ☐ N
Allergy Shots	☐ Y ☐ N	**Fractures**	☐ Y ☐ N	**Mumps**	☐ Y ☐ N	**Suicide Attempt**	☐ Y ☐ N
Anemia	☐ Y ☐ N	**Glaucoma**	☐ Y ☐ N	**Osteoporosis**	☐ Y ☐ N	**Thyroid Problems**	☐ Y ☐ N
Anorexia	☐ Y ☐ N	**Goiter**	☐ Y ☐ N	**Pacemaker**	☐ Y ☐ N	**Tonsillitis**	☐ Y ☐ N
Appendicitis	☐ Y ☐ N	**Gonorrhea**	☐ Y ☐ N	**Parkinson's**	☐ Y ☐ N	**Tuberculosis**	☐ Y ☐ N
Arthritis	☐ Y ☐ N	**Gout**	☐ Y ☐ N	**Pinched Nerve**	☐ Y ☐ N	**Tumors**	☐ Y ☐ N
Asthma	☐ Y ☐ N	**Heart Disease**	☐ Y ☐ N	**Pneumonia**	☐ Y ☐ N	**Typhoid Fever**	☐ Y ☐ N
Bleeding Disorder	☐ Y ☐ N	**Hepatitis**	☐ Y ☐ N	**Polio**	☐ Y ☐ N	**Ulcers**	☐ Y ☐ N
Breast Lump	☐ Y ☐ N	**Hernia**	☐ Y ☐ N	**Prostate Problems**	☐ Y ☐ N	**Vaginal Infections**	☐ Y ☐ N
Bronchitis	☐ Y ☐ N	**Herniated Disc**	☐ Y ☐ N	**Prosthesis**	☐ Y ☐ N	**STD's**	☐ Y ☐ N
Bulimia	☐ Y ☐ N	**High BP**	☐ Y ☐ N	**Psychiatric Care**	☐ Y ☐ N	**Whooping Cough**	☐ Y ☐ N
Cancer	☐ Y ☐ N	**High Cholesterol**	☐ Y ☐ N	**Rheumatoid Arthritis**	☐ Y ☐ N	**Other**	______________
Cataracts	☐ Y ☐ N	**Kidney Disease**	☐ Y ☐ N	**Rheumatic Fever**	☐ Y ☐ N		______________
Chemical Dependency	☐ Y ☐ N	**Liver Disease**	☐ Y ☐ N				______________
Chicken Pox	☐ Y ☐ N	**Measles**	☐ Y ☐ N				
Diabetes	☐ Y ☐ N	**Migraines**	☐ Y ☐ N				
		Miscarriage	☐ Y ☐ N				

Medications/Supplements/Vitamins

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____
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Allergies

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Injuries/Surgeries

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