Welcome to our Practice!

As a new patient, please fill out the information below to the best of your ability.

1 PATIENT INFORMATION

Patient's Social Sec. # | Date of Birth | Age

First Name | Middle Initial | Last Name

Mailing Address

City | State | Zip Code

Home Phone | Cell | Work

Employer | Occupation

❑ Male ❑ Female | ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced # of children:

Spouse or Parent (if minor) - Name | Employer

Cell | Work

Who referred you to our office?

2 INSURANCE INFORMATION

Please complete the following section and present your insurance cards.

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Relation to Insured	❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other
Insured's Name		
Insured's Birth Date	/ / ❑ Male ❑ Female	/ / ❑ Male ❑ Female
Member ID		
Group #		
Employer		

3 ACCIDENT INFORMATION

Please complete only if your condition is due to an accident/injury.

CLAIM FILING INFORMATION

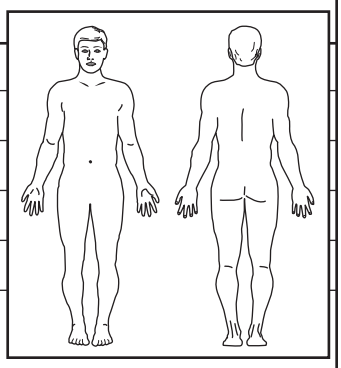
Accident Type	❑ Auto Accident ❑ Other Personal Injury ❑ Work Related
Date of Injury/Accident	
Insurance Carrier Name	
Carrier Address	
City, State, Zip	
Adjuster's Name	
Adjuster's Phone Number	
Claim Number	

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the chiropractic physician to diagnose and treat my condition(s). Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims by provider or agent. **I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. Accounts not paid after 90 days of service will be charged 18% annual interest, 1.5% monthly.** Additionally, I authorize this office to release any and all of my medical records as deemed necessary. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

SIGNATURE | DATE

OVER PLEASE

4 PATIENT CONDITION



Reason for visit:

When did your symptoms appear?

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Same

Mark an X on the picture where you have pain, numbness or tingling

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)

Type of pain ❑ Sharp ❑ Dull ❑ Throbbing ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Have you seen a chiropractor before? When? Name

How often is this pain present? ❑ Occasional 0-25% ❑ Intermediate 26-50% ❑ Frequent 51-75% ❑ Constant 76-100%

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

5 PERSONAL HEALTH HISTORY

What treatment have you already received for your condition?
❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Care ❑ None ❑ Other

Family Medical Physician (Name, Address, Phone)

Place a mark to indicate if you have had any of the following:

AIDS/HIV	❑ Yes ❑ No	Ear Infections	❑ Yes ❑ No	Irregular Bowel Movements	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Alcoholism	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Vaccinations	❑ Yes ❑ No
Allergy Shots	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Liver Problems	❑ Yes ❑ No	Sciatica	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fractures	❑ Yes ❑ No	Measles	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Appendicitis	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Mononucleosis	❑ Yes ❑ No	Stomach Ulcers	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Goiter	❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Gout	❑ Yes ❑ No	Mumps	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Breast Lump	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Recurring Colds	❑ Yes ❑ No
Bronchitis	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Recurring Flu	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Parkinson's Disease	❑ Yes ❑ No	Recurring Strep/ Sore Throats	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	Hernia	❑ Yes ❑ No	Pinched Nerve	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Herniated Disk	❑ Yes ❑ No	Pneumonia	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Chicken Pox	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Polio	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Depression	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Prostate Problem	❑ Yes ❑ No	Tumors, Growths	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Impotence	❑ Yes ❑ No	Prosthesis	❑ Yes ❑ No	Typhoid Fever	❑ Yes ❑ No
Digestive Problems	❑ Yes ❑ No	Infertility	❑ Yes ❑ No			Whooping Cough	❑ Yes ❑ No

Work Activity ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Exercise ❑ None ❑ Moderate ❑ Daily ❑ Heavy

Habits ❑ Smoking _____# Packs/Day
❑ Alcohol _____# Drinks/Week
❑ Coffee/Caffeine Drinks _____# Cups/Day

Do you wear any of the following? ❑ Heel Lifts ❑ Innersoles ❑ Arch Supports ❑ Orthotics ❑ Other:

Vitamins, Herbs currently taking

INJURIES/SURGERIES YOU HAVE HAD:	DESCRIPTION	DATE
Falls, Broken Bones, Head Injuries		
Other		
Surgeries (Please include cosmetic implants)		

6 CURRENT MEDICATIONS

MEDICATION	DOSAGE	FOR WHAT CONDITION?	HOW LONG HAVE YOU BEEN TAKING THIS?