



About you

Patient Name: _____ Date: _____
Last First MI

What do you prefer to be called: _____ () Male () Female

Birthdate: ____/____/____ Age: ____ SS#: ____-____-____

Mailing Address: _____
City State Zip

Home Phone #: (____) ____-____ Work Phone #: (____) ____-____ Ext: _____

Other Phone #s: _____ E-mail Address: _____@_____

Referred By: _____

Employer: _____ How long? _____

Occupation: _____ Address: _____
City State Zip

Status: () Minor () Single () Married () Divorced () Separated () Widowed

Spouse's Name: _____

Do you have children? () Yes () No How many? _____

Insurance Information

Company Name: _____ Phone #: _____

Address: _____
City State Zip

Insured's ID#: _____ Group #(plan, local, or policy #): _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

Reason for Visit

The reason for this visit is: () Work () Auto () Sports () Trauma () Chronic () Other

Explain what happened: _____

Please describe pain & its location: _____

When did this condition begin? ____/____/____

Is this condition... () getting worse () constant () comes and goes () worse in morning
() worse at night

Does anything make it better or worse? _____

Is this condition interfering with your: () Work () Sleep () 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? () Yes () No

If so, where? _____



Have you ever been treated by a Chiropractor before? ()Yes ()No
If so, whom? _____ Phone #: _____

Health/Medical History

Are you currently being treated for any conditions? ()Yes ()No
If so, explain? _____

Please list any other serious medical conditions in your past? _____

Have you had any surgeries/hospitalizations? (Please list dates) _____

Have you had any PAST serious accidents? (Please list dates) _____

Family Health History (present and past): _____

Current Medications & for what condition?

Medication	Condition	Dosage	Amount/day

Do you take vitamins or supplements? ()Yes ()No
If so, what kind? _____

Have you had or do you have any of the following diseases or conditions? (please circle)

- | | | |
|--------------------------------|-----------------------------|-----------------------|
| Y N Heart Attack/Stroke | Y N Heart 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 Emphysema | Y N Glaucoma |
| Y N Anemia | Y N High/low blood pressure | Y N Ulcers/Colitis |
| Y N Psychiatric problems | Y N Rheumatic fever | Y N Asthma |
| Y N Kidney Problems | Y N Sinus Problems | Y N Chemotherapy |
| Y N Severe/frequent headaches | Y N Difficulty breathing | Y N Arthritis |
| Y N Fainting/Seizures/Epilepsy | Y N Artificial bones/joints | Y N Diabetes |
| Y N Tuberculosis | Y N Lower back problems | Y N Numbness |

Exercise: ()Yes ()No Smoke: ()Yes ()No Alcohol: ()Yes ()No

Are you wearing: ()Heel lifts ()Sole lifts ()Inner soles ()Arch supports

Women: Birth Control: ()Yes ()No Pregnant: ()Yes/how long ____ ()No Nursing: ()Yes ()No



Emergency Contact

Who should we contact? _____ Relation: _____

Phone # _____ Alternate # _____

Who is your medical doctor? _____ Phone # _____

Pay Flex Account

Name of person responsible for account: _____

Billing Address (if different than mailing): _____

_____ / _____ / _____
City State Zip

Payment method: ()Cash ()Check ()Visa/Discover/Mastercard

_____ / _____
Enter card # above Expiration date

_____(initials) 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).

Signature Agreement

- 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.

Signature of Patient: _____ Date: ____/____/____

Parent/Guardian Signature: _____ Date: ____/____/____