



A PROFESSIONAL CORPORATION

Welcome to our office!

Please fill out our Health Records as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be a service to you.
Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About The Patient

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone (_____) _____
Cell (_____) _____
Birth Date _____
Gender Male Female # of Children _____
Employer _____
Work Address _____
Work Phone _____
Type of Work _____
Marital Status Married Single Divorced
 Separated Widowed
Social Security # _____
E-mail Address _____

Payment Method Cash Check Credit Card
CC# _____ Exp: ____ / ____

About the Spouse or Parent

Name _____
Employer _____
Work Address _____
Work Phone _____
Type of Work _____

Reason For This Visit

Describe the purpose of this visit _____

Is the purpose of this appointment related to

- Job Sports Auto Fall
 Chronic Discomfort Home Injury Other

Please explain _____

If job related, have you made a report of your accident to your employer Yes No

When did this condition begin _____

Has this condition Gotten Worse Stayed Constant

Does this condition interfere with

- work sleep daily routine other activities

Please explain _____

Has this condition occurred before Yes No

Explain _____

Have you seen other doctors for this condition

- Yes No

Dr.'s Name (s) _____

Type of Treatment _____

Results _____

Experience With Chiropractic

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes No

Reason for those visits? _____

Doctor's Name _____

Approximate Date of last visit? _____

Has any *adult* in your family seen a Chiropractor? Yes No

Has any *child* in your family seen a Chiropractor? Yes No

Awareness of Chiropractic Principles

Were you aware that...

Doctors of Chiropractic work with the nervous system? Yes No

The nervous system controls all bodily functions and systems? Yes No

Chiropractic is the largest natural healing profession in the world? Yes No

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies.

Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care:** Symptomatic relief of pain or discomfort.
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care appropriate for my condition.

Patient's Signature

Date

Medication I Now Take

- Nerve Pills
- Pain Killers (including Aspirins)
- Muscle Relaxers
- Blood Pressure Medicine
- Insulin
- Stimulants
- Blood Thinners
- Tranquilizers
- _____
- _____

Health Habits

- Do you smoke? Yes No
- Do you drink alcohol? Yes No
- Do you drink coffee? Yes No
- Do you exercise regularly? No Moderate Daily
- Do you wear Heel Lifts Sole Lifts
 Inner Soles Arch Supports

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- Severe or Frequent Headaches
- Sinus Problems
- Loss of Sleep
- Pain Between the Shoulders
- Frequent Neck Pain
- Numbness or Pain in Arms/Legs/Hands
- Lower Back Problems
- Digestive Problems
- Ulcers/Colitis
- Heart Attack/Stroke
- Thyroid Problems
- Kidney Problems
- Hepatitis
- Cancer
- Congenital Heart Defect
- Heart Surgery/Pacemaker
- High/Low Blood Pressure
- Difficulty Breathing
- Asthma
- Arthritis
- Alcohol/Drug Abuse
- Venereal Disease
- HIV/AIDS
- Diabetes
- Tuberculosis
- Shingles
- Chemotherapy
- Anemia
- Rheumatic Fever
- Psychiatric Problems

FOR WOMEN ONLY

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Are you taking birth control?
 Yes No
- Do you experience painful periods?
 Yes No
- Do you have irregular cycles?
 Yes No
- Do you have breast implants?
 Yes No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deem appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Patient Signature

Date

Guardian or Spouse's Signature

Date

Who should receive bills for payment for your account?

- Patient Spouse Parent Worker's Comp.
 Medicare Personal Health Insurance Auto Insurance

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

EMERGENCY CONTACT

Name _____

Relationship _____

Work Phone _____

Home Phone _____

MY HEALTH INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company _____ Policy # _____

Address _____ Group # _____

Phone Number _____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security # _____

Relationship _____ Date of Birth _____