WELCOME TO

Please Print Clearly and Fill In Completely

Name: ______________________________ Date of Birth: _______________ ❑ Male ❑ Female
Address: ____________________________ City: _________________ State: _____ Zip: __________
Home Phone: ____________________________ Cell Phone: ________________________________
E-mail address _____________________________________ Social Security #: _______________
Your Occupation: ______________________ Your Employer: ______________________________
Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Widowed
Name of Spouse or Nearest Relative: _____________________________ Phone: ______________
Referred to this Office by: ❑Friend/Family Member - Name? _____________________________
❑Yellow Pages ❑Mail ❑Radio ❑Other_______________

INSURANCE INFORMATION

Payment for Services will be by: ❑Cash ❑Check ❑Health Ins. ❑Auto Ins. ❑Worker's Comp.
Name of Insurance Co.:_____________________ Insured's Employer: _________________________
Name of Insured/Policy Holder: ________________________ Relation to Insured: ______________
Insured's Social Security #:________________________ Insured's Birth Date: _________________
Are you covered by more than one insurance company? ❑Yes ❑No Name: ________________

HEALTH HISTORY

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

❑ anemia	❑ dislocated joints	❑ neck pain	❑ indigestion
❑ asthma	❑ cancer	❑ nervousness	❑ diabetes
❑ back pain	❑ numbness	❑ sinus trouble	❑ convulsions
❑ bladder trouble	❑ headaches	❑ bowel control loss	❑ high blood pressure
❑ bone fracture	❑ heart trouble	❑ poor circulation	❑ concussion

List any past surgeries & dates: ____
List any past accidents & dates: ____
Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Describe Condition_____________________________ Date of Last Physical Exam______________
Describe any current health problems, including how long you have had them: ________________
____
List any current medications: ____
Females: Is there a possibility of you being pregnant? ❑Yes ❑No

CHIROPRACTIC HISTORY:

Have you ever been to a Doctor of Chiropractic? ❑Yes ❑No Doctor ____________________
Date of last chiropractic visit_________Reason for care _____________________________________
Date of last chiropractic x-rays_________How long were you under care? ____________________
Are other family members under chiropractic care? ❑Yes ❑No Who? ___________________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your Symptoms (1 - 10, with 1 being least serious) **(1 – 10)**

1.____ ________

2.____ ________

3.____ ________

WHEN AND HOW OCCURRED?____

____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑bending ❑sitting ❑standing ❑walking ❑lying down ❑turning head
❑reaching ❑lifting ❑coughing ❑sneezing ❑straining at stool ❑_______________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑bending ❑sitting ❑standing ❑walking ❑lying down ❑turning head
❑reaching ❑lifting ❑____

SYMPTOMS DEVELOPED FROM: ❑job related injury ❑auto accident ❑other accident
❑illness ❑unknown cause ❑gradual onset date occurred:__________
SYMPTOMS HAVE PERSISTED FOR #: ___hour(s) ___day(s) ___week(s) ___month(s) ___year(s)
SYMPTOMS/COMPLAINTS: ❑come & go ❑are constant
SYMPTOMS ARE WORSE IN: ❑morning ❑afternoon ❑night

HAVE YOU EVER HAD THIS BEFORE: ❑yes ❑no when?____________________
If you were to guess, what do you think is causing your complaints?_______________

____

NAME AND LOCATION OF DOCTORS SEEN FOR PRESENT CONDITION(S):

____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

❑headaches ❑light bothers eyes ❑stomach upset ❑head seems heavy
❑blurred vision ❑loss of balance ❑diarrhea ❑numbness in fingers
❑cold sweats ❑fainting ❑fever ❑numbness in toes
❑cold feet ❑buzzing in ears ❑constipation ❑pins and needles in arms
❑dizziness ❑ringing in ears ❑muscle jerking ❑pins and needles in legs
❑stiff neck ❑fatigue ❑insomnia ❑depression /weeping spells
❑cold hands ❑shortness of breath ❑concentration loss /confusion
❑other____

Patient's Signature:___________________________ **Date:**______________

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this office the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office.

A photocopy of this assignment shall be considered as effective and valid as the original.

____________________________________ _______________

Patient Signature Date

RELEASE OF INFORMATION

I authorize this office to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case; and hereby release this office of any consequence thereof.

____________________________________ _______________

Patient Signature Date

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co payment and any services rejected by my insurance company.

____________________________________ _______________

Patient Signature Date

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United states alone by doctors of chiropractic.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, ______________________ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

__________________________________ __________________

(Signature) (Date)