

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible when completing this form. **IF SOMETHING DOES NOT APPLY, WRITE N/A.** Thank you.

PERSONAL:

Patient Name _____ Sex: _____ Age: _____ Birth Date: _____
Title First M.I. Last M or F Mth-Day-Year

Home Address: _____ Home Phone: _____
No PO's # Street City State Zip

Your SS# _____ Employer & Address: _____ Work Phone: _____ ext.

Spouse/ Partner's Name _____ Employer & Address: _____ Work Phone: _____ ext.

Marital Status: _____ # of children _____
M-S-W OR D 2 People we can call in case of an emergency & Phone #'s

If Student, School Name, Address & Grade: _____ Parent(s) Mother: _____
Name(s) Father: _____

If Student, Parent Home Address: _____ Parents (H): _____
if different # Street City State Zip Phone (W): _____
A/C # ext.

Referred to our office by: _____ Is this an injury from an accident? Work Auto Home Personal Injury Other

Cell Phone #: _____ Fax Home: _____ Fax Work: _____ Pager Number: _____

E-Mail Home: _____ Work: _____ Other: _____

INSURANCE: Fill out this section if Worker's Compensation (Company W/C carrier), No Fault (your NF carrier), or with your group health carrier information.

1st Company: _____ Policy Holder: Myself Father Mother
 Spouse Other
Name Address Phone # Birth Date
ID# _____ Plan Name: _____ Policy/Group#: _____ of 1st Person Insured

2nd Company: _____ Policy Holder: Myself Father Mother
 Spouse Other
Name Address Phone # Birth Date
ID# _____ Plan Name: _____ Policy/Group#: _____ of 2nd Person Insured

Patient's Relationship to 1st Policy Holder: Self Spouse Child Other Name: _____

Patient's Relationship to 2nd Policy Holder: Self Spouse Child Other Name: _____

Other Insurance Info: _____

Yearly Deductible \$ _____ Co-Payment \$ _____ / _____ % REFERRING DOCTOR: _____

I allow payment of all medical benefits directly to this office. I understand that all fees are my responsibility and that I will pay any and all unpaid balance due. I also authorize this office to furnish any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. My signature also serves as a release to acquire information from other health providers via fax, mail, e-mail or verbally on myself or minor child. A photocopy of this agreement/assignment/release shall be considered as effective and valid as the original. I also understand that if my case proves to be non-work or non-auto related, I will be responsible to this office for all bills at normal office rates. If I discontinue care on my own at any time, any balance due will be payable in full immediately regardless of insurance coverage. This office will assist you submitting your insurance, but there is no guarantee that they will pay.

Signature of Patient/Parent

Signature of Policy Holder

FOR ALL WORK, AUTO, PERSONAL INJURIES/ACCIDENTS, ANSWER THE FOLLOWING:

Date & Time of Injury: _____ AM PM City/State where injured: _____

Taken to Hospital Where : _____ Doctor Seen: _____

Lost work: _____ to _____ Are You: Improving The Same Getting Worse Totally Disabled Partially Disabled
Date Out Date Back

Did you hire an attorney? yes no Name/Address: _____

What hurt or was injured at the time of the accident? _____

Did you ever have an injury to this body part before? yes no When? _____

Your Vehicle: Street On: _____ Speed: _____ mph Direction Traveling: _____

Other Vehicle: Street On: _____ Speed: _____ mph Direction Traveling: _____

Did you see the impact coming? yes no Was you head turned at the time of the impact yes no Which Way? _____

You were Driver Passenger Front Back Wearing Safety Belts Knocked Unconscious Airbag Deployed Others Injured? Names: _____

Did your car get pushed/moved? yes no How? _____

FOR A WORK RELATED INJURY, ANSWER THE FOLLOWING:

Employer when injured w/Address: _____

What work related activities/jobs can you not perform: _____

HEALTH REPORT

Describe all reasons for seeking chiropractic care: Spinal Evaluation Scoliosis Poor Posture Neck Pain Mid-Back Pain Low Back Pain

Improved Health Prevention/Wellness Subluxation Correction Improved Sports Performance Improved Immune Function Cranial Care

Other - Describe: _____

Describe in detail HOW your problem started: _____

Date your problem started/1st symptoms: _____ Date of similar condition: _____

Doctors seen for this condition: _____

ALL medications now taking: _____

List all broken bones: _____ Recent X-Rays within 3 months: _____

List all surgeries: Tonsils Adenoids Hysterectomy Appendix Gallbladder Hernia Back Neck Heart Carpal Tunnel Eye

Other Surgeries/Procedures: _____

List all serious accidents: (car, falls, sports etc.) _____

List all family diseases: _____

List health problems of spouse & children: _____

Previous Chiropractic Care? yes no If yes: Neck problem Low Back Problem Prevention Wellness Boost Immunity Enhance sports performance

Last resort for health condition - What condition? : _____ Other reason: _____

Does your job require: Standing Sitting Lifting Driving Walking Job Title : _____

Daily job activities: _____

Do you sleep on your: Back Side Stomach Cervical Pillow Waterbed Firm mattress Air Mattress Foam Mattress

Do you smoke? yes no _____ packs a day Cigarettes Cigars Pipes Chewing I quit _____ ago

Do you exercise: Daily Weekly Occasional Never Walk Swim Lift Run Golf Other _____

Your: Height _____ Weight _____ Race _____ Nationality _____ Handed: Left Right Both

