Welcome

1 ABOUT YOU

Today's Date: ____________________

Name ____
LAST FIRST MI

What do you prefer to be called: ________________________

Birth date __ __ / __ __ / __ __ Age ____________________

❒ Male ❒ Female

Address ____

City____________________ State ______ Zip _________

Cell Phone #: ____________________________________

Home Phone #: ____________________________________

Work Phone #'s: ___________________________________

Email: ____

Who may we thank for referring you? ________________

Status: ❒Minor ❒Single ❒Married ❒Divorced ❒Separated ❒Widowed

Spouse's Name: ___________________________________

Do you have children? ❒ Yes ❒ No

If Yes, please list their names and ages:

_____________________________________ __________

_____________________________________ __________

_____________________________________ __________

2 EMPLOYER INFO

Employer: ______________________How Long? _____

Employer's Address: ____________________________

____
CITY STATE ZIP

Occupation ____________________________________

3 INSURANCE INFO

Company Name: _____________________________

Address: ______________________________________

____
CITY STATE ZIP

Phone Number: _______________________________

Insured's ID #: _______________________________

Group # (Plan, Local, or Policy #) _______________

Insured's Name: _______________________________

Relationship _____________ Date of Birth _________

Insured's Employer: ____________________________

4 REASON FOR VISIT

The reason for this visit is a result of (Please circle):

General Health and Wellness **Sports** **Fall** **Injury** **Other**

Explain concern: ____

____

If a condition is present, please describe the pain & its location: _______________

____

When did condition begin? ______________________

Is this condition getting worse? ❒ Yes ❒ No ❒ Constant ❒ Comes and Goes

Is this condition interfering with your (Please circle): 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 under the care of a Chiropractor before? ❒ Yes ❒ No

If so, whom? ___________________________ Phone #: _________________

SYSTEM SIGN-IN PIN

Please choose a four (4) digit PIN number that will be easy for you to remember when you sign-in. (suggestion: last four (4) digits of social security number)

PLEASE CONTINUE ON BACK

5 IN EVENT OF EMERGENCY

Who should we contact? ____

Relation: ______________________________

Cell Phone #: ______________________ Work Phone #: ______________________

Who is your Medical Doctor? ________________ Phone # ____________________

6 HEALTH HISTORY

Please list all medications - both prescription and over the counter: _______________

____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./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 / Glaucoma	**Y N** Anemia
Y N High / Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones	**Y N** Arthritis

Have you had COVID-19? ❒ Yes ❒ No When? ______________________

Have you had the COVID shot? ❒ Yes ❒ No When? ______________________

Please list any other serious medical condition(s) you have or ever had: __________

____

Please list anything that you may be allergic to: ___________________________

____

List previous surgeries/treatments with dates: ______________________________

____

List **past** serious accidents with dates: __________________________________

____

Family Health History: ____

____

What Nutritional supplements or vitamins do you take? ______________________

____

What is your current exercise program? _____________________________

Are you on a special diet: ❒ Yes ❒ No Since: ____/____/____

Do you smoke? ❒ Yes ❒ No / How much? ________ How long?

Are you wearing: ❒ Heel Lift ❒ Sole lifts ❒ Inner soles ❒ Arch supports

What is the age of your mattress? _____________ Is it comfortable? ❒ Yes ❒ No

For Women: Are you using birth control? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No / How long? _______ Nursing? ❒ Yes ❒ No

7 ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________

Relation: ______________________

Billing Address: ________________

____
City State Zip

D.L.# ________________________

Work Phone # __________________

Payment Method: ❒ CASH ❒ CHECK

❒ CREDIT CARD

______ 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).
Initials

- 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 Practice Member.
- 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 ___________________________________ Date ___/___/___

❒ Adult Patient ❒ Parent or Guardian ❒ Spouse

ABOUT YOU

Name: ____

What is your current weight: _______ lbs., and height, ______Ft. ______In.
Please describe your condition:

____

____

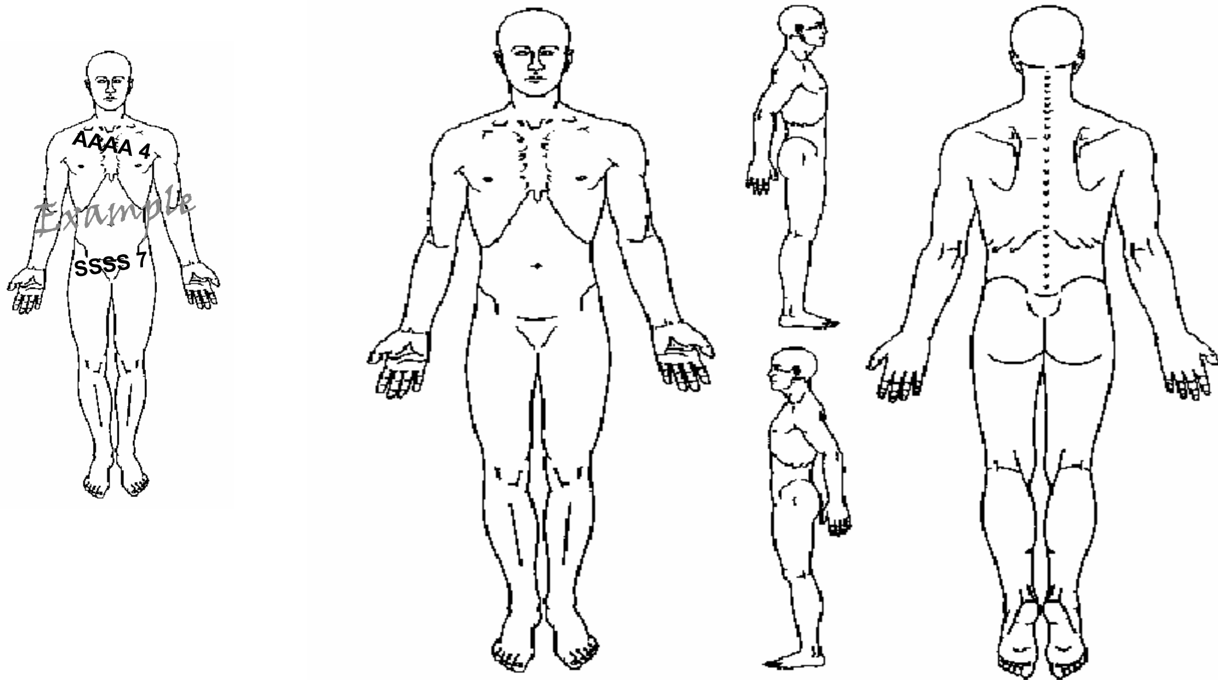
Signature: ____ Date: _____/_____/_____

SHOW US

If you have pain, we have provided the following chart. Please mark **area(s)** of injury or discomfort as indicated below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

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