Welcome to Amesbarry Chiropractic

Patient Information

Patient's Name:_____ Date:_____
First Middle Last

First name you prefer us to call you by_____

Patient's Date of Birth:_____/_____/_____ ☐ Female ☐ Male

Address:_____ Apt/Unit#:_____

City:_____ State:_____ Zip Code:_____

Cell# :_____ Work #:_____ Home#:_____

Email Address:_____

Circle one: Minor Single Married Divorced Widowed

Parent or Guardian name if patient is a minor:_____

Who should we contact in case of emergency? _____

Who referred you or how did you find out about us?_____

Your Employer Company Name :_____

City and State of Employer:_____

Have you been in an auto accident or work accident in the last 6 months? Yes No If yes date_____

General Insurance Information – skip to auto accident info if visit is due to auto accident.

Insurance Company:_____ Phone: _____

ID#_____ Group/Account#:_____

2nd Insurance Company:_____ Phone:_____

ID#_____ Group/Account#:_____

Auto Accident Insurance Information:

Date of Accident:_____ Did you inform your insurance company of accident? Yes No

Insurance Company:_____ Phone: _____

Claim #:_____

Attorney's Name:_____ Phone:_____

Work Comp Injury Information:

Date of Injury:_____ Did you report this injury to your employer? Yes No

Employer/Manager Contact Name:_____

Phone:_____

Symptoms

What are you being seen for today?_____

When did you first experience symptoms?_____

Has this condition progressively become worse? Yes No Issue comes and goes Issue is constant

Which activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Circle any of the following pain:

Sharp Throbbing Numbness Aching Shooting Dull Tingling Cramps Stiffness Swelling

Rate the severity of your issue. 1 being mild discomfort, 10 being severe: 1 2 3 4 5 6 7 8 9 10

What treatment have you received for this already? _____

Name of Clinic/s you have been to:_____

Health History **Circle only the conditions you have had:**

Aids/HIV	Breast Lump	Emphysema	Hernia	Mononucleosis	R.A.
Alcoholism	Bronchitis	Epilepsy	Herniated Disc	Multiple Sclerosis	Rheumatic Fever
Allergy shots	Bulimia	Fractures	Herpes	Mumps	Scarlet Fever
Anemia	Cancer	Glaucoma	High Cholesterol	Osteoporosis	Stroke
Anorexia	Cataracts	Goiter	Kidney Disease	Pacemaker	Thyroid Issues
Appendicitis	Chicken Pox	Gonorrhea	Liver Disease	Pneumonia	Tumors/Growths
Arthritis	Depression	Gout	Measles	Polio	Ulcers
Asthma	Diabetes	Heart Disease	Migraines	Prostrate Issues	Whooping Cough
Bleeding disorder	Drug Addiction	Hepatitis	Miscarriage	Prosthesis	

List any surgeries and dates:_____

Medications you take:_____

Vitamins/Supplements you take:_____

Women Only: Are you pregnant? Yes No Nursing? Yes No Taking birth control? Yes No

Daily Habits

What type of exercise do you do on a weekly basis? None/very little Moderate Heavy

Daily work habits: Sitting Standing Light Labor Heavy Labor Computer Work

If you smoke packs per week?_____ Amount of alcohol consumed weekly?_____

Amount of caffeine consumed daily?_____

General Consent to treat and Assignment of Benefits

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my or my child's health. I consent to necessary diagnostic and/or chiropractic and/or acupuncture treatment for my condition. I understand I am financially responsible for all services I receive whether I have insurance coverage or not or should my insurance company deny payment for my services. I authorize the use of my signature on all insurance submissions. I certify that if I and/or my dependent/s has insurance coverage, I request payment of authorized benefits from _____ directly to Amesbarry Chiropractic

Name of Insurance Co.

for services rendered. The doctor may use and disclose my health care information to the above insurance company or third-party administrators for the purpose of obtaining payment for services payable. I understand this consent continues unless I cancel in writing to Amesbarry Chiropractic.

Signature of Patient or Legal Representative_____ Date_____

If Signing for patient print your name & relationship_____