Welcome to West Chiropractic Clinic

Patient Information

Thank you for choosing West Chiropractic Clinic for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: ____ SS/HIC/Patient ID #: ________________

First Middle Initial Last

Address: ______________________________ City: _________________ State: _____ Zip Code: __________

Sex: ❑ Female ❑ Male Birthdate: ______________ E-mail: ______________________________

Home Phone: (_____)______________ Cell Phone: (_____)______________ Work Phone: (_____)______________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ____ years

Patient Employer/School: ___________________________________ Occupation: ________________

Employer/School Address: __________________ City: _________________ State: _____ Zip Code: __________

Spouse or parent's name: __________________ Employer: ______________ Work Phone: (_____)______________

Whom may we thank for referring you to us? ____

Person to contact in case of emergency: ______________________________ Phone: (_____)______________

Responsible Party

Name of person responsible for this account: ____

Relationship to patient: ____ Phone: (_____)______________

Address: ______________________________ City: _________________ State: _____ Zip Code: __________

Name of employer: ____ Work Phone: (_____)______________

Insurance Information

Name of insured: __________________________ Relationship to patient: __________________________

Birthdate: ____________________ Social Security#:: ________________ Date employed: ________________

Name of employer: ____ Work Phone: (_____)______________

Address: ______________________________ City: _________________ State: _____ Zip Code: __________

Insurance Co.:____________________ Phone: (_____)______________ Group #:_____ Employer #: __________

Insurance Co. address: ____________________ City: _________________ State: _____ Zip Code: __________

How much is your deductible? ________ How much have you used? ___________ Max. annual benefit? __________

Do you have additional insurance? ❑ Yes ❑ No **If Yes, please complete the following:**

Name of insured: __________________________ Relationship to patient: __________________________

Birthdate: ____________________ Social Security#:: ________________ Date employed: ________________

Name of employer: ____ Work Phone: (_____)______________

Address: ______________________________ City: _________________ State: _____ Zip Code: __________

Insurance Co.:____________________ Phone: (_____)______________ Group #:_____ Employer #: __________

Insurance Co. address: ____________________ City: _________________ State: _____ Zip Code: __________

How much is your deductible? ________ How much have you used? ___________ Max. annual benefit? __________

Symptoms

Reason for visit: ______________________ When did you first notice the symptoms? ______________

Is the condition getting progressively worse? ________ Where specifically is the problem(s) located? ____________

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ______________________________

What treatment have you received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other ______________________

Name and address of other doctor(s) who have treated you for your condition:

____

Health History *Check only those conditions which are applicable:*

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostrate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other ________
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	____________
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke	____________

Dates of last exams: ______________________________

(Woman) Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking Birth Control Pills? ❑Yes ❑No

List any types of surgeries which you have had and the dates which they occurred: ______________________

____

Please list all medications you are currently taking: ______________________

Allergies: ______________________________

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? ______________________

What vitamins do you currently take? ____________ Nutritional supplements (if any)? ____________

Do you smoke? ❑ Yes ❑ No How much per day? ______________________

How much liquor do you consume weekly? ______ How many caffeinated beverages do you consume daily? ______

Certification and Assignment

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 I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to West Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

West Chiropractic Clinic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ ____________

Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ____________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient