MAHER Chiropractic

A Family Tradition of Chiropractic Care Since 1934

PATIENT INFORMATION FORM

Today's Date _____/_____/_____

ABOUT YOU

Name:_____ What you prefer to be called:_____
Birthdate: _____/_____/_____ Age: _____ SS#: _____-____-_____ Male____ Female____
Mailing Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-Mail:_____ Referred By: _____
Employer:_____Occupation: _____
Marital Status: ____Minor ____Single ____Married ____Divorced ____Separated ____Widowed
Spouse's Name: _____ Any children? ___Y ___N How Many? _____

REASON FOR VISIT

The reason for this visit is a result of (Please circle): Work Sports Auto Trauma Chronic
Explain what happened: _____
Please describe the pain & its location: _____
_____

When did this condition begin? ____/____/____ Is it getting worse? __Y__N ___Constant ___Comes & Goes

Is this condition interfering with your (Please circle): Work Sleep Daily Routine
If so, please explain:_____
Have you had this or a similar condition in the past? ___Y ___N
If so, please explain:
_____
Have you been treated by a medical physician for this condition? ___Y ___N
If so, where? _____
Have you ever been treated by a chiropractor before? ___Y ___N
If so, whom?_____ Phone: _____

INSURANCE: If you have insurance that may cover chiropractic, please provide your current insurance card so that we may make a copy.

IN CASE OF EMERGENCY

Who should we contact? _____ Relation: _____
Home Phone: _____ Work Phone: _____
Who is your medical doctor? _____ Phone: _____

HEALTH HISTORY

Are you taking any of the following medications? ___Pain medication (including aspirin) ___Muscle relaxers
___Blood thinners ___Insulin ___Anti-Inflammatories ___Other(s) _____

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

Y N Heart Attack/Stroke
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N HIV+/Aids
Y N Frequent Neck Pain
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Fainting/Seizures/Epilepsy
Y N Diabetes
Y N Lower Back Problems

Y N Heart Surgery/Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles
Y N Emphysema
Y N Psychiatric Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones/Joints
_____
_____

Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer _____
Y N Anemia
Y N Rheumatic Fever
Y N Ulcers/Colitis
Y N Asthma
Y N Chemotherapy
Y N Arthritis

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

_____

Please list anything you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Family Health History:_____

DO YOU:
Take supplements or vitamins? ___Y ___N
Exercise? ___Y ___N
Are you on a special diet? ___Y ___N Since: ____/____/____
Do you smoke? ___Y ___N How much?_____ How long? _____
Are you wearing: ___Heel lifts ___Sole lifts ___Inner soles ___Arch supports
What is the age of your mattress? _____ Is it comfortable? ___Y ___N

For Women:
Are you taking birth control? ___Y ___N
Are you pregnant? ___Y ___N How far along? _____ Nursing? ___Y ___N

ACCOUNT INFORMATION
** 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.*
** 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 date of service and no other 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: _____/_____/_____