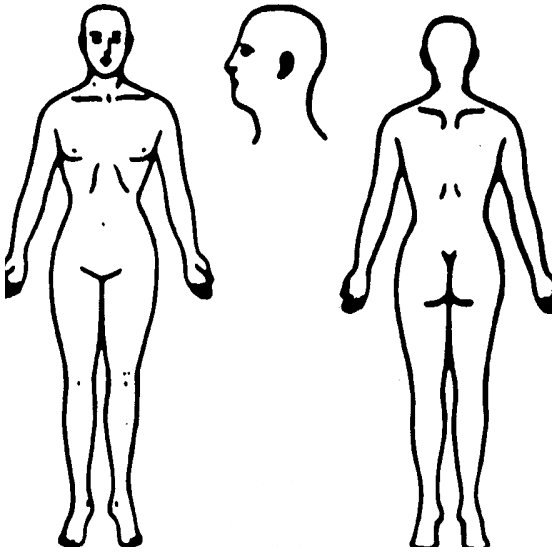
PATIENT NAME _____ DATE_____
STREET ADDRESS_____
CITY_____ STATE_____ ZIP _____
PHONES: HOME_____ WORK _____ CELL _____
E-MAIL_____ BIRTHDATE_____ AGE_____
OCCUPATION_____ EMPLOYER_____
REFERRED BY_____

Check if you are: ☐ Married/Partnered ☐ Single ☐ Widowed ☐ Divorced
Number of Children _____ Name of spouse/partner_____
If minor, name of responsible party _____

Describe Primary Health Concern _____
_____
Rate your concern:
(0=no problem 10=most severe) **0 1 2 3 4 5 6 7 8 9 10**
When/How did it begin_____
Any previous treatment_____
Made better by _____ Made worse by _____
Any other concerns _____
Prior Injuries (Include dates) _____
Hospitalizations/Surgeries _____
Allergies (food or drug) NO YES List _____
Currently under care of a health care practitioner for this concern NO YES
Previous chiropractic care NO YES Doctor's Name_____
Dates of Treatment_____ Results?_____

Put an X on all areas of concern:



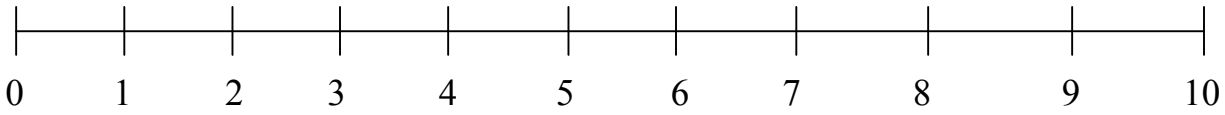
Family Health History

Relation	Age	Previous Serious Illness
Spouse		
Children		
Father		
Mother		
Sisters		
Brothers		

DO YOU TAKE/USE:

Nutritional supplements NO YES List_____
Medications NO YES List _____
Candy/Sweets NO YES List _____
Special Diet NO YES List _____
Tobacco Products NO YES Chew Pipe Cigars Cigarettes #/day _____
Soft Drinks NO YES Regular Diet #cans/day_____
Alcohol NO YES Drinks/day-week-month (circle one) _____
Coffee NO YES Cups/day _____
Tea NO YES Herbal Caffeinated Cups/day _____
Average hours of sleep/night_____ Bowel Frequency_____
Hours of work/week _____
Exercise (forms and frequencies)_____

How would you rate your overall health (10 being best):



Please read before signing:
Payment is required at the time of service. Please check which method (s) of payment you prefer:

☐ CASH ☐ CHECK ☐ CREDIT/ DEBIT (Visa, MasterCard, Discover)

At your request we will gladly provide you with statements to use for insurance reimbursement.

☐ Check this box if you think you may file with your insurance company at any time in the foreseeable future.

- Please be aware that by making an initial appointment with our doctors, you are agreeing to abide by the billing policies of our practice. You will be charged for your appointment if you forget it or do not provide at least 24 hours notice of a cancellation or change in your appointment date/time. Exceptions will be made for weather and/or emergency situations.
- We invite you to discuss with us any questions regarding our services. The best care is based on a friendly, mutual understanding between chiropractor and patient. We want to be part of your health care team.
  By signing below:
- I authorize the staff and chiropractic physicians to perform any services needed during diagnosis and treatment.
- I authorize the provider to release any information required to process insurance claims. I understand and agree that health insurance is an agreement between the carrier and myself and that all services rendered are charged directly to me and that I am personally responsible for payment, even if I terminate my care.
- I understand any and all information collected in this office is confidential and I also understand it is my responsibility to inform this office of any changes to the information I have provided.

- I acknowledge that I have read and understand the HIPAA Privacy Act. **INITIAL HERE:** _____

SIGNATURE _____ **DATE** _____