Ludwig Chiropractic Center, PS

Alan S Ludwig, DC

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Welcome to our office. *In order for us to best serve you and to understand your health concerns it is imperative that* ***all*** *areas of this form be completely filled out. Thank you.*

Today's date _____

Name _____ Birth date ____ / ____ / ____ How young are you? _____

SSI # _____ Marital status: ☐M ☐S ☐D ☐W Spouse/Partners name: _____ # of children _____

Home address _____ email _____
Street City / State Zip

Home phone (__) _____ Cell phone (__) _____ Work phone (__) _____ Ext _____

Occupation _____ Who may we thank for referring you to our office? _____

If you have had chiropractic care before, for what condition and when? _____

List the condition(s) that have brought you to our office in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

List other doctors consulted for these conditions:

1. _____ Address: _____
2. _____ Address: _____

Any X-rays, MRI's or CT scans taken in the last year and for what condition? _____

Is today's condition related to a work injury? _____ If so, have you reported it to your employer? _____

Is today's condition related to an auto accident? _____ If so, have you reported it? _____ Your auto ins. Co. _____

Policy # _____ Claim# _____ Agent's Name and Ph # _____

NOTICE: All first visit charges, whether examination, x-rays, and/or treatment, are payable when service is rendered. If you have insurance coverage, co-pays and deductible are due when service is rendered. In the event we have not been able to verify insurance benefits a minimum payment of 20% of the days charges will be due at that time.

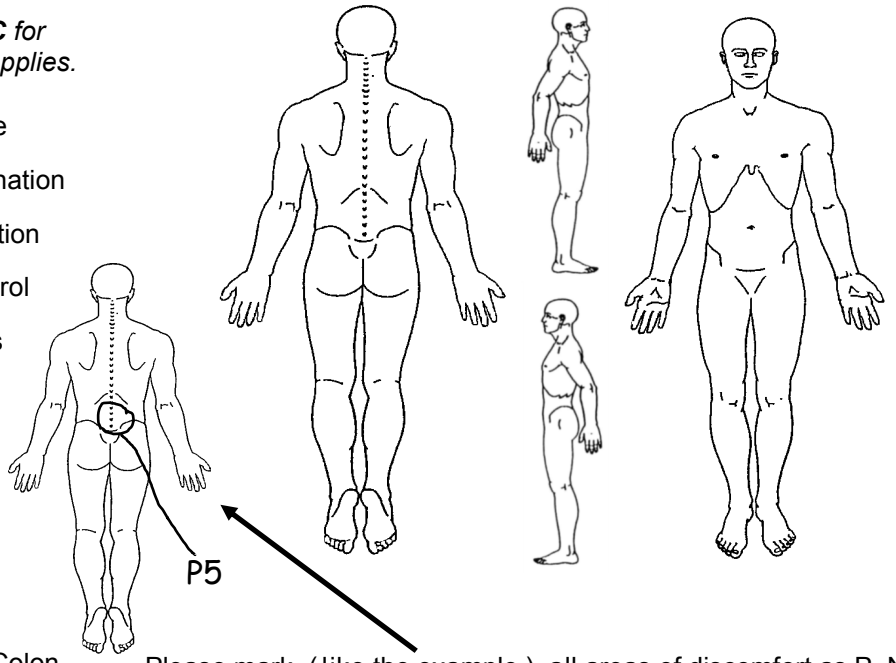
Injuries/Surgeries: Please list *ALL* Auto accidents, Falls, Surgeries, Sprains, Dislocations or Broken bones and Left or Right.

Describe	Date	Describe	Date

OFFICE USE ONLY

SYMPTOMS *Please Circle **P** for past conditions and **C** for current conditions when it applies. Circle both if that applies.*

P	**C**	Headaches	**P**	**C**	Heart Trouble
P	**C**	Dizziness	**P**	**C**	Frequent Urination
P	**C**	Ear Infections	**P**	**C**	Painful Urination
P	**C**	Fatigue	**P**	**C**	Bladder Control
P	**C**	Nausea	**P**	**C**	Belching/Gas
P	**C**	Neck Pain	**P**	**C**	Acid Reflux
P	**C**	Arm/Hand Pain	**P**	**C**	Constipation
P	**C**	Arm/Hand Numbness	**P**	**C**	Asthma
P	**C**	Mid Back Pain	**P**	**C**	Diabetes
P	**C**	Shoulder Pain	**P**	**C**	Sleep Apnea
P	**C**	Low Back Pain	**P**	**C**	IBS/Spastic Colon
P	**C**	Sciatica	**P**	**C**	Difficult Breathing
P	**C**	Leg/Foot Pain	**For Women Only**		
P	**C**	Leg/Foot Numbness	**P**	**C**	Painful Periods
P	**C**	Allergies	**P**	**C**	Excessive Flow
P	**C**	High Bld. Press.	**P**	**C**	Irregular Cycle



Please mark (like the example) all areas of discomfort as P, N, T, etc. and write the severity on a scale of 1 mild — 10 severe.

Pain……...P
Numbness……N
Tingling…….T
Aching……...A
Burning …….B
Sore……...S

Are your symptoms getting? :

- ☐ Better
- ☐ Worse
- ☐ Staying the same

Financial / Insurance Policy:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor ' s Office will process any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor ' s Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Signature _____ Date _____

Authorization To Release Information

To: Alan S. Ludwig, D.C.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charger incurred by me as a result of professional services rendered by you, and I hereby release you of any consequences thereof.

Signature _____ Date _____