first chiropractic CENTERS P.C.

Patient Number _____
(office use only)

Today's Date: _____

Have you consulted a chiropractor before? ○ No ○ Yes

_____
Whom may we thank for referring you?

When? _____ If so, Where? _____

First Name	MI	Last Name	Birthdate	Age	Gender ○M ○ F
Address	City		State	Zip	
Cell Phone	Home Phone	Work Phone	Social Security #		
E-mail Address		Employer			
Marital Status ○ Single ○ Married ○ Widowed ○ Other	Spouse Name	# of Children	Ages ○ 0-5 ○ 5-10 ○10-18 ○ Adult		
Primary Language ○ English ○ Spanish ○ Other	Tobacco Use ○ Smoke ○ Chew ○ None	Preferred Communication ○ Cell Phone ○ Home Phone ○ Work Phone ○ E-mail	Method of payment you plan to use to take care of today's charges. ○ Cash ○ Check ○ Credit Card		
Emergency Contact	Emergency Contact's Phone	Primary Physician			

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **I may request a copy of the Financial Policy at any time.**

Initials ____ **I authorize my insurance company or administrator to pay First Chiropractic Centers, PC directly for the Benefits otherwise payable to me under my current policy**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____
Signature Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

Patient Number _____
(office use only)

first chiropractic CENTERS P.C.

_____
Patient Name

I am interested in: ○ Chiropractic Care ○ Stretches and Exercise ○ Nutritional Advice
○ Acupuncture ○ Wellness Care ○ Quit Smoking

Please state your reason for coming in today.

1. _____

   For how long? _____

2. _____

   For how long? _____

3. _____

   For how long? _____

Have you had any spinal, arm or leg surgeries? ○ No ○ Yes

1. _____
2. _____
3. _____
4. _____

Consultation Notes

Mechanism
Intensity
Frequency
Radiation
AF
RF
Past Episodes

Vitals: (completed by staff)

H: _____
W: _____
P: _____
BP: _____
BMI: _____
T: _____
R: _____
O_2: _____

Patient Name:

Patient Number (office use):_____

Review of Systems

Please check beside any current or past concerns

- O Neck Problems
- O Back Problems
- O Joint Problems
- O Scoliosis
- O Swollen Joints
- O Arthritis
- O Anxiety/Depression
- O Weakness
- O Headache/Migraines
- O Dizziness
- O Numbness/Tingling
- O High Cholesterol
- O High Blood Pressure
- O Asthma
- O Seasonal Allergies
- O Shortness of Breath
- O Emphysema or COPD
- O Abdominal Pain
- O Kidney Stones
- O Constipation
- O Diarrhea

Past Medical History

Illnesses

- O Diabetes
- O Cancer
- O Epilepsy
- O Multiple Sclerosis
- O Stroke
- O Heart Disease
- O Shingles
- O Other _____
- O None

Operations

- O Cardiovascular Surgery
- O Cancer
- O Other _____
- O None

Family History

- O Stroke
- O Cancer
- O Cardiovascular Disease
- O Diabetes
- O Other _____
- O None

Social History

Exercise

- O Daily
- O Weekly
- O Never/Not Much at All

Tobacco Use

- O None
- O Smoke
- O Smokeless

List Prescription Medications (We can happily make a copy of your list instead of writing here)

_____

_____

_____

List Vitamins and Supplements

_____

_____

_____

Is there anything else we should know?

_____

_____

_____