



**About You**

File # \_\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

Name \_\_\_\_\_ Prefer to be called \_\_\_\_\_

Email Address \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status  Single  Married  Divorced  Separated  Widowed

**Reason For Visit**

The reason for this visit is a result of (Please Circle): work, sports, auto, trauma or chronic.

(Explain what happened):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe the pain & its location: \_\_\_\_\_

When did condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and Goes

Is this condition interfering with your (Please circle): work, sleep, or daily routine.

If so, explain \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

If so, where? \_\_\_\_\_

Have you ever been treated by a Chiropractor before?  Yes  No

If so, whom? \_\_\_\_\_ Phone# \_\_\_\_\_

**Insurance Info**

**Primary**

Company Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Insured's SS #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer \_\_\_\_\_ (Please inform front desk of 2nd Insurance Source)

**Secondary**

Company Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Insured's SS #: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer \_\_\_\_\_

**In Event Of An 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?

- Nerve pills  
  Pain killers (including aspirin)  
  Muscle relaxers  
  Stimulants  
  Blood Thinners  
  Tranquilizers  
  Insulin  
 Other(s) \_\_\_\_\_

Have you ever had any of the following diseases/medical conditions(s)?

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Heart Attack/Stroke     | <input type="checkbox"/> Heart surg/Pacemaker | <input type="checkbox"/> Heart Murmur     | <input type="checkbox"/> Congenial Heart Defect         |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Artificial Valves    | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Alcohol / Drug Abuse           |
| <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> HIV+/Aids            | <input type="checkbox"/> Shingles         | <input type="checkbox"/> Cancer                         |
| <input type="checkbox"/> Frequent Neck Pain      | <input type="checkbox"/> Emphysema /Glaucoma  | <input type="checkbox"/> Anemia           | <input type="checkbox"/> High /Low Blood Pressure       |
| <input type="checkbox"/> Psychiatric Problems    | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Sinus Problems   | <input type="checkbox"/> Severe /Frequent Headaches     |
| <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ulcers /Colitis      | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Fainting / Seizures / Epilepsy |
| <input type="checkbox"/> Diabetes / Tuberculosis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chemotherapy     | <input type="checkbox"/> Lower Back Problems            |
| <input type="checkbox"/> Articial Bones / Joints | <input type="checkbox"/> 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 smoke?  No  Yes / How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Are you wearing:  Heel Lifts  Sole Lifts  Inner Soles  Arch Supports

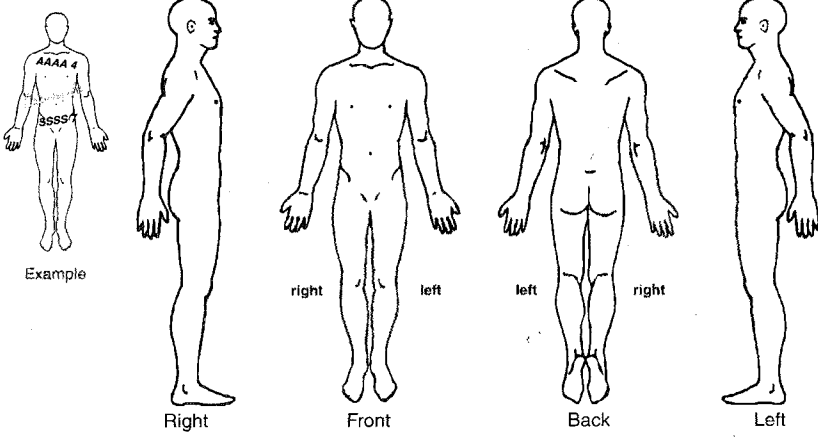
### For Women:

Are you taking birth control?  Yes  No Are You Pregnant?  No  Yes/How Long \_\_\_\_\_ Nursing?  Yes  No

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	→ Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

○ Circle any area of pain not represented by a symbol.



- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- 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 the date of service and no 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 in my medical status.

Signature \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_