WELCOME

one

ABOUT YOU

Today's Date: _____/_____/_____

Name: _____

What You Prefer To Be Called: _____ Male Female

Birthdate: _____/_____/_____ Age: _____ SS#_____

Home Address: _____

_____
CITY STATE ZIP

Home Phone #:_____

Other Phone #s: _____

e-mail: _____

May we send our informational newsletter and event announcements (infrequently) to your e-mail address? **Yes No**
(we will never sell your e-mail address to anyone ever)

Referred By: □ Current Patient: Name:_____
□ Yellow Book □ Verizon Book □ Website □ Other _____

Employer & Address: _____

_____
CITY STATE ZIP

Occupation: _____ Work Phone # _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: _____

two

OFFICE USE ONLY

Co. Name: _____

Benefits Available? Yes NO

COPAY: _____

Deductible: _____

Patient Coinsurance:_____%

Benefit Limits: _____

_____

Other Info: _____

REASON FOR VISIT

Have you ever been treated by a Chiropractor? Yes No
Have you ever been treated by a Naturopathic Physician? Yes No
If so, when?: _____
What did you see them for? _____

_____

Are your primary complaints the result of an automobile accident, work injury, or other cause (please circle one)?

What is your **primary symptom or area of pain**?: _____

_____

Circle your desire to heal the problem (10 highest): 0 1 2 3 4 5 6 7 8 9 10
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, please explain: _____
Have you had this or similar conditions in the past? Yes No
If so, please explain: _____
Have you been treated by a Medical Physician for this condition? Yes No
If so, where? _____
What other treatments have you attempted for this condition? _____

_____

three

PLEASE CONTINUE ON BACK

REASON FOR VISIT CONTINUED

What is your **secondary symptom or area of pain**?: _____

_____

Circle your desire to heal the problem (10 highest): 0 1 2 3 4 5 6 7 8 9 10

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, please explain: _____

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

If so, please explain: _____

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

If so, where? _____

What other treatments have you attempted for this condition? _____

_____

_____

(If you have additional goals, please write them on the blank side of the form.)

What type of care are you NOT interested in, if recommended to help you:

Chiropractic Dietary Recommendations Nutritional Supplements

Acupressure Herbs Exercises Detoxification

CONTINUED FROM FRONT

DIETARY AND LIFESTYLE

List the 5 foods (including drinks) you consume most often: BE HONEST!!

1)_____

2)_____

3)_____

4)_____

5)_____

How much water do you drink a day (in cups)? _____

What kind of exercise do you do?_____

_____

How often? _____

Do you want to lose weight? _____

How much? _____

How long do you want to live? (circle and check one).

60 ____ As long as I'm healthy and not a burden to others

65 ____ Whenever my number's up

70 ____ Forever

75 ____ It's already enough

80

85

90

100+

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Med. Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxants Stimulants

Blood Thinners Tranquilizers Insulin Blood Pressure Meds

Cholesterol Meds Other(s) _____

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

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / AIDS	Y N Shingles	Y N Arthritis
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Bulged Discs	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/Joints	

Y N Psychiatric Disorder (Please Specify): _____

Y N Cancer (Please Specify): _____

If you circled yes to any of the above conditions, please explain: _____

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

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

What is your stress level on a scale of 1-10? _____

What is the quality of your sleep? Good Fair Poor

How many bowel movements do you have per day? ____ week? ___

How many hours a week do you exercise? _____

five six

IMPORTANT HEALTH INFO

Family Health History: Cancer
Depression Diabetes Arthritis

Digestive/Gallbladder Problems
♥ Disease Other _____

Do you smoke? No Yes
How Much? _____ How Long? _____
Do you drink alcohol? No Yes
How much? _____ drinks/wk

What is your height? ____ft. ____in.

What is your current weight? _____lbs.

What is your blood type? A B AB O

For women: Are you taking Birth Control?
Yes No

Are you Pregnant?
No Yes/How long? _____
Nursing? Yes No

- 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 to assess my condition and care for me in the office. I also authorize the provider 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.
- **OFFICE POLICY:** Scheduled appointments must be rescheduled the da

Signature _____ Date ___/___/___