

Patient Information

Date _____

Name _____
Last First MI

(Preferred Name) _____

Address _____
City State Zip

E-mail _____

Sex: M F Age _____ Date of Birth _____

Married Widowed Single
 Separated Divorced

Patient Employer/School _____

Occupation _____

Employed/School: Full-Time Part-Time Not Employed Retired

Cell Ph (_____) _____ Home Ph (_____) _____

Best time and place to reach you _____

Emergency Contact: _____

Phone # _____

Referred by/how did you hear of us? _____

Have you ever seen a Chiropractor? Yes No

If Yes, when? _____

Self Pay or Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Address _____
City State Zip

Is this Self-Pay (no insurance)? Yes No

Do you have HSA Flex Spending

Insurance Co. _____

Group # _____ ID # _____

Subscriber's Name _____

Subscriber's Date of Birth _____ Relationship to Patient _____

Assignment and Release
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to the rendering (Name of Insurance Company) provider all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

_____ **Date** _____ **Relationship to Patient**

ACCIDENT INFORMATION

Is this condition due to an accident? Y N
 If yes date of accident _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Work Comp Other

Attorney Name(if applicable) _____

Exercise

None

Moderate

Daily

Heavy

Type _____

Work activity

Sitting

Standing

Light Labor

Heavy Labor

Habits

Smoking Packs/Day _____

Alcohol Drinks/Week _____

Coffee/Caffeine Drinks Cups/Day _____

Eating Habits (Describe) _____

Patient Condition

Please mark the intensity of your pain today: 0 – No Pain 10 – Excruciating Pain, Type of Pain: N-Numbness, T-Tingling, S-Soreness, P-Pain, A-Ache, ST-Stiffness, MSP-Muscle Spasm

Example: Low Back Pain	0 1 2 3 4 5 6 7 8 9 10	ST, MSP	5 years	<input type="radio"/> Y <input type="radio"/> N When _____
1. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____	<input type="radio"/> Y <input type="radio"/> N When _____
2. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____	<input type="radio"/> Y <input type="radio"/> N When _____
3. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____	<input type="radio"/> Y <input type="radio"/> N When _____
4. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____	<input type="radio"/> Y <input type="radio"/> N When _____
5. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____	<input type="radio"/> Y <input type="radio"/> N When _____
6. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____	<input type="radio"/> Y <input type="radio"/> N When _____

Family History of Illness

	Diabetes	Heart	Cancer	Headaches	Neck Pain	Back Pain	Other	Deceased
Mother (Age____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Age____
Father (Age____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Age____
Brother (# of____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Age____
Sister (# of____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Age____

Please check the box below for each item below. Past (more than one year.) Current (less than one year)

	Past Current	Past Current	Past Current	Past Current
GENERAL SYTEMS			GASTRO-INTESTINAL	
<input type="checkbox"/> <input type="checkbox"/> Memory Loss		<input type="checkbox"/> <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Tattoo/Piercings
<input type="checkbox"/> <input type="checkbox"/> Chills		<input type="checkbox"/> <input type="checkbox"/> Excessive Hunger/Thirst	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Moles
<input type="checkbox"/> <input type="checkbox"/> Convulsions		<input type="checkbox"/> <input type="checkbox"/> Heartburn	<input type="checkbox"/> <input type="checkbox"/> Poor Cirulation	<input type="checkbox"/> <input type="checkbox"/> Boils
<input type="checkbox"/> <input type="checkbox"/> Dizziness		<input type="checkbox"/> <input type="checkbox"/> Belching or Gas	<input type="checkbox"/> <input type="checkbox"/> Light Headed (Positional)	<input type="checkbox"/> <input type="checkbox"/> Brusng Easily
<input type="checkbox"/> <input type="checkbox"/> Fainting		<input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> Rapid Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Dryness
<input type="checkbox"/> <input type="checkbox"/> Fatigue		<input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> Slow/Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/> Eczema/Psoriasis
<input type="checkbox"/> <input type="checkbox"/> Fever		<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Hives
<input type="checkbox"/> <input type="checkbox"/> Headache		<input type="checkbox"/> <input type="checkbox"/> Poor Digestion	<input type="checkbox"/> <input type="checkbox"/> Strokes	<input type="checkbox"/> <input type="checkbox"/> Itching
<input type="checkbox"/> <input type="checkbox"/> Loss of Sleep		<input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Sensitive Skin
<input type="checkbox"/> <input type="checkbox"/> Hernia		<input type="checkbox"/> <input type="checkbox"/> Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Swelling Ankles	<input type="checkbox"/> <input type="checkbox"/> Skin Eruptions
<input type="checkbox"/> <input type="checkbox"/> Anxiety		<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Rashes
<input type="checkbox"/> <input type="checkbox"/> Mood Changes			<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Sweating
<input type="checkbox"/> <input type="checkbox"/> Irritability				
SPINE		EYE/EAR/NOSE/THROAT	RESPIRATORY	WOMEN ONLY
<input type="checkbox"/> <input type="checkbox"/> Jaw Pain/Click (TMJ)		<input type="checkbox"/> <input type="checkbox"/> Glasses/Contact Lenses	<input type="checkbox"/> <input type="checkbox"/> Allergy	<input type="checkbox"/> <input type="checkbox"/> Menstral Cramps
<input type="checkbox"/> <input type="checkbox"/> Neck Pain/Stiffness		<input type="checkbox"/> <input type="checkbox"/> Excessive Hunger/Thirst	<input type="checkbox"/> <input type="checkbox"/> asthma/Wheezing	<input type="checkbox"/> <input type="checkbox"/> PMS
<input type="checkbox"/> <input type="checkbox"/> Upper Back Pain		<input type="checkbox"/> <input type="checkbox"/> Light Sensitive	<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain		<input type="checkbox"/> <input type="checkbox"/> Blurred/Double Vision	<input type="checkbox"/> <input type="checkbox"/> Chronic Cough	<input type="checkbox"/> <input type="checkbox"/> Excessive Flow
<input type="checkbox"/> <input type="checkbox"/> Lower Back Pain		<input type="checkbox"/> <input type="checkbox"/> Deafness	<input type="checkbox"/> <input type="checkbox"/> Bronchitis	<input type="checkbox"/> <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> Numbness, Tingling or Pain in Buttocks, Legs, Thighs, Feet, Toes		<input type="checkbox"/> <input type="checkbox"/> Ear Ache/Infection	<input type="checkbox"/> <input type="checkbox"/> Spitting Blood	<input type="checkbox"/> <input type="checkbox"/> Hot Flashes
<input type="checkbox"/> <input type="checkbox"/> Numbness, Tingling or Pain in Arms, Hands, or Fingers		<input type="checkbox"/> <input type="checkbox"/> Ear Discharge	<input type="checkbox"/> <input type="checkbox"/> Spitting Phlegm	<input type="checkbox"/> <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> Difficulty w/Excessive (standing, walking, sitting, riding, bending, lifting, twisting, or household chores		<input type="checkbox"/> <input type="checkbox"/> Ear Ringing	GENTO-URINARY	<input type="checkbox"/> <input type="checkbox"/> Miscarriage
<input type="checkbox"/> <input type="checkbox"/> Foot Trouble		<input type="checkbox"/> <input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> <input type="checkbox"/> Bladder/Kidney Infection	<input type="checkbox"/> <input type="checkbox"/> Painful Periods
<input type="checkbox"/> <input type="checkbox"/> Spinal Curvature		<input type="checkbox"/> <input type="checkbox"/> Hoarseness	<input type="checkbox"/> <input type="checkbox"/> Blood in Urine	<input type="checkbox"/> <input type="checkbox"/> Breast Problems
<input type="checkbox"/> <input type="checkbox"/> Joint Pain		<input type="checkbox"/> <input type="checkbox"/> Sore Throats	<input type="checkbox"/> <input type="checkbox"/> Bed Wetting	<input type="checkbox"/> <input type="checkbox"/> Pregnant
<input type="checkbox"/> <input type="checkbox"/> Muscle Twitching		<input type="checkbox"/> <input type="checkbox"/> Sinusitis	<input type="checkbox"/> <input type="checkbox"/> Frequent Urination	MISCELLANEOUS
<input type="checkbox"/> <input type="checkbox"/> Broken Bones		<input type="checkbox"/> <input type="checkbox"/> Tonsillitis	<input type="checkbox"/> <input type="checkbox"/> Inability to Control Urine	<input type="checkbox"/> <input type="checkbox"/> Unexplained Weight Loss/Gain
<input type="checkbox"/> <input type="checkbox"/> Fractures		<input type="checkbox"/> <input type="checkbox"/> Hay fever	<input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> Recent Infection/Night Weats
			<input type="checkbox"/> <input type="checkbox"/> Prostate Problems	<input type="checkbox"/> <input type="checkbox"/> Night Pain
			<input type="checkbox"/> <input type="checkbox"/> Impotene	<input type="checkbox"/> <input type="checkbox"/> Loss of Bowel/Bladder Function
				<input type="checkbox"/> <input type="checkbox"/> Pain Wakes You From Sleep
				<input type="checkbox"/> <input type="checkbox"/> Numb/Tingling in <u>BOTH</u> Arms and/or Legs

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis Type?
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other_____
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Liver/Gall Bladder	<input type="checkbox"/> HIV Positive	

List all Surgeries, Falls, Accidents, and Injuries (even those you thought were no big deal) and dates if known:

Incident _____ Date: _____
 Incident _____ Date: _____
 Incident _____ Date: _____
 Incident _____ Date: _____
 Incident _____ Date: _____

Have you ever had x-rays taken? Yes No When? _____ By Whom? _____

What ailments were these x-rays made? _____

Who Is your Primary Care Physican? _____

List all Drugs and Nutritional Supplements you are taking (include prescription and over the counter medications/supplements such as: birth control, aspirin, multivitamin, etc.) Use back page if needed

Type	Purpose	Dosage

Activities of Daily Living

- Type of Mattress (describe) _____ How Old? _____
- Sleeping Position? Side Stomach Back
- Type of Pillow? Down Feather Foam
- Average Hours of Sleep? _____
- Do you sit in a Recliner? Always Often Never
- Do you Wear Orthotics/Heel Lifts? Yes No If yes were the impressions made sitting or standing? _____
- Do you sit on your wallet? Yes No
- Define your Stress Level (use 1 - 10 scale, 10 being the most stressful): _____ Work _____ Home

I hereby attest that the above information and health history I have provided is complete and accurate. I understand the importance of providing a truthful health history in order to assist the doctor in providing the best chiropractic care possible. I hereby authorize the Doctor to examine and treat my condition as he deem appropriate through the use of Chiropractic Health Care, and give authority for these procedures to be performed.

Our Insurance Service to you:
 Chiropractic and Wellness will submit to your insurance company an all claims for services rendered here. We will do our best to receive compensation for services from your insurance company. However, if your insurance company does not comply and refuses to pay, then it is your responsibility to pay the balance incurred at our office promptly. This means we expect payment on your account within 30 days of notification by your insurance company that the claim has been denied, put towards deductible, co-insurance or not paid for any other reason.

I agree that if I fail to make payments and keep my account current, services may be denied an may be denied and my account balance will be due in full. I also understand that it is policy of Chiropractic and Wellness that my balance shall not exceed \$200.00 at anytime.

Massage cancellation Policy:
 We have a 24 hour cancellation policy. YOU WILL BE CHARGED THE FULL AMOUNT OF THE MASSAGE if you do not cancel or reschedule your massage 24 HOURS prior to your scheduled appointment. *This will not be billed to your insurance company* LATE POLICY If you are late, the appointment will start ASAP and the appointment will end at the originally scheduled time AND YOU WILL BE CHARGED FOR THE FULL AMOUNT OF THE SESSION.

Collection Agency/Attorney Fees:
 If your account is sent to our collection agency/attorney, the fees for this process will be added to your account. The balance due to Chiropractic and Wellness will remain in full.

Patient/Legal Guardian Signature **X** _____ Date _____