Patient Id#_____

(Please Print) **Patient History** Date:_____

Name:_____ Email:_____ Home Ph:_____
Address, City, Zip_____
Wk Ph:_____ Cell Ph:_____
Birth Date:_____ Age:_____ ☐ Male ☐ Female Spouse's Name (Parent):_____
#of Children_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Occupation:_____

How were you referred to our office?_____ Social Security#:_____

Have you ever had chiropractic care before?_____ If yes, when?_____

List your chief complaints in order of severity:
1._____ For how long?_____
2._____ For how long?_____
3._____ For how long?_____

Rate the pain of your chief complaints on a scale from 0-10. (0= No pain, 10= Severe pain)
1._____ 2._____ 3._____

List other doctors consulted for this condition:
1._____ Address:_____
2._____ Address:_____

Is this injury work related?_____ Have you reported it to your employer?_____

Is this injury related to an automobile accident?_____ If yes name YOUR:
Auto Ins Co:_____ Policy#_____ Claim#_____
Address:_____
Phone#_____ Agent's Name:_____

Do you have any type of health insurance?_____ Company_____
Address_____ ID#:_____

Are you covered under any other group or individual health policy through yourself or spouse?_____
If yes, Company Name:_____ Address:_____
Spouse's Social Security#:_____ Employer:_____
Address, City, State, Zip:_____
If you have an insurance card or Medicare card please let our staff take a copy for your file.

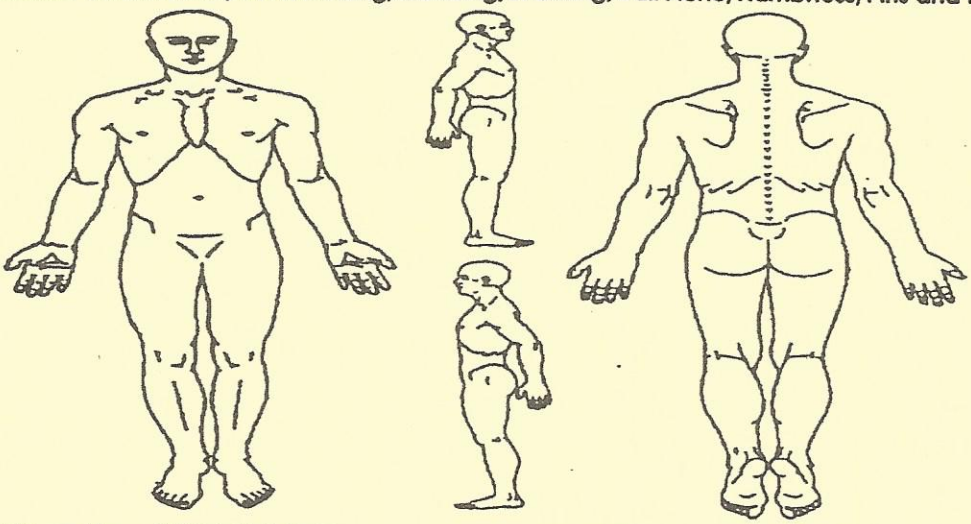
Notice: Not all patients require x-rays to determine or verify a diagnosis, type and length of care. If your examination warrants x-ray analysis, the following office policy prevails:

1. All first visit charges are to be paid when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

Method of payment for today's charge: ☐ Cash ☐ Check ☐ Credit Card

Patient's Signature:_____

Mark the areas on your body where you feel pain. Include all affected areas.
Describe whether the pain is Burning/Stabbing/Shooting/Dull Ache/Numbness/Pins and Needles



When and how did this first start? _____ **What makes condition better/ worse?** _____
Describe Pain: ☐ Constant ☐ Comes & Goes ☐ Better ☐ Worse ☐ Same
Has it happened before? ☐ Yes ☐ No If yes, when? _____
Does the pain radiate? ☐ Yes ☐ No If yes, where? _____
What have you done for condition in the past? _____

Health History (Check if you have ever had any of the following:)

- ☐ Abdominal Aortic Aneurysm
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ UTI
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other: _____

HABITS:
Exercise ☐ Yes ☐ No If yes, explain how often and type: _____
Smoke ☐ Yes ☐ No If yes, how often? _____
Alcohol ☐ Yes ☐ No If yes, how often? _____
Caffeine ☐ Yes ☐ No If yes, how much? _____
High Stress Level ☐ Yes ☐ No If yes, reason? _____

FAMILY HISTORY: (Please list all known conditions/illnesses that apply to the following relatives)
Mother: _____ Father: _____
Grandparents: _____ Siblings: _____
Other known familial conditions: _____

Is there anything else you think we should know about or that you would like to discuss? (Explain) _____

Authorization of Care

I authorize and agree to allow the Doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

Patient's signature	Date	Parent/Guardian	Date

IN CASE OF EMERGENCY CALL:

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carrier may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Patient's Signature_____Date_____