

# PATIENT INFORMATION

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Position \_\_\_\_\_ Address \_\_\_\_\_  
Marital status - *circle one* [ S M W D ] Are You Insured? [ Y N ] Ins. Company \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Are you Pregnant? [ Y N ] Number of children \_\_\_\_\_  
Referred by \_\_\_\_\_

Have you had chiropractic care before? \_\_\_\_\_ When? \_\_\_\_\_

What is your current complaint? \_\_\_\_\_

Is this condition due to:

- Auto accident
- Work injury
- Other accident
- Illness
- Unknown cause

Date symptoms appeared \_\_\_\_\_

Are symptoms:

- Improving [101]
- About the same [102]
- Getting worse [103]
- Intermittent [come and go] [104]

Check any activities which aggravate your condition:

- Standing
- Lying
- Bending
- Coughing
- Twisting
- Walking
- Sitting
- Lifting

Other doctors seen for other problems:

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

List all prescription drugs you now take: [108]

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

List all non-prescription drugs you now take: [109]

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

Have you had these symptoms Before?

- No [105]
- Yes When? \_\_\_\_\_

List all previous accidents:

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

Check here if you

- smoke [110]
- don't exercise regularly [111]

Who is your general practitioner? Dr. \_\_\_\_\_

[106]

List all surgical operations: [107]

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

Check here if you have a family history of:

- arthritis [112]
- cardiovascular disease [113]
- diabetes [114]
- cancer [115]

Would you like us to send a report to your general practitioner?

- Yes
- No

*I understand and agree that medical insurance policies are an arrangement between my insurance company and myself - not my insurance company and this office. I authorize this office to release any medical information and complete any usual and customary reports and forms at no charge, to assist in collecting from my insurance company. However, I understand that I am ultimately responsible for payment in full and agree to pay a \$10 per month billing charge and a 1.5% monthly interest charge for all unpaid balances, which become 30 days past due. If necessary, I also agree to take full responsibility for all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.*

*I have read this financial policy. I understand and agree to all the terms of this policy.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
[Parent's signature if minor]

Please check the type of care desired so that we may be guided by your wishes when possible:

- Temporary relief
- Control of immediate problem
- Total healthcare
- I prefer the Dr. to select the type of care he feels is best for me