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]

Have you had these symptoms Before?

☐ No [105]
☐ Yes When? _____

Who is your general practitioner?
Dr. _____ [106]

Would you like us to send a report to your general practitioner?
☐ Yes ☐ No

Check any activities which aggravate your condition:

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

Other doctors seen for other problems:

_____
_____
_____

List all previous accidents:

_____
_____
_____

List all surgical operations: [107]

_____
_____

List all prescription drugs you now take: [108]

_____
_____
_____
_____

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

_____
_____
_____

Check here if you

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

Check here if you have a family history of :

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

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