



## ABOUT YOU Today's Date: File #:\_ Patient Name: LAST FIRST What You Prefer To Be Called: \_ ☐ Male ☐ Female Birthdate: / / Age: SS#: Mailing Address: CITY STATE Home Phone #: Work Phone #:\_ Ext: Other Phone #s: E-Mail Address: Referred By: Employer: How Long? Employer's Address: CITY STATE Occupation: Status: A Minor Single Married Divorced Separated Widowed Spouse's Name: Do you have children? ☐ Yes ☐ No How many?

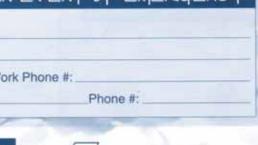


10000	INSURANCE	INFO
Co. Name:		
Address:		
CITY	STATE	ZIP
Phone #:		
Insured's ID#:		
Group # (Plan, Local, or Po	olicy #):	
Insured's Name:		
Relation:	Date of Birth:	1_1_
Insured's Employer: Please inform front of	desk of 2nd, Insurance sou	rce,

REASON FOR VISIT
The reason for this visit is a result of (Please circle): work, sports, auto, trauma or chronic.
(Explain what happened ):
Please describe the pain & its location:
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?
Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No
If so, whom? Phone#:



PLEASE CONTINUE ON BACK



The state of the s	
Work Phone #:	
Phone #	

		NO VAN
	HEALT	TU LISTORY
Are you taking any of the	he following medicat	tions?
☐ Nerve pills ☐ Pain killers (inclu ☐ Blood Thinners ☐ Tranquili:	zers Insulin Other(s	3)
Do you have or ever had any		
	Y N Heart Surg/Pacemaker	
	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 Gancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	
Y N High/Low Blood Pressure	Y N Psychiatric Problems Y N Kidney Problems	Y N Hneumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Actions
Y N Fainting/Seizures/Epilepsy Y N Diabetes / Tuberculosis		Y N Asthma
Y N Liabetes / Tuberculosis Y N Lower Back Problems	Y N Difficulty Breathing Y N Artificial Bones / Joints	V N Arthritic
Please list any other serious		
List previous surgeries/trea		_
Family Health History:		
Do you: Take Supplements	or Vitamins?   Yes   No /	Exercise? Tyes N
Are you on a special diet:	Yes No / Since:	
Do you smoke? ☐ No ☐ Ye Are you wearing: ☐ Heel Li		the same of the sa
What is the age of your ma For women: Are you taking Are you Pregnant?   No   No   No   No   No   No   No   N	g Birth Control? ☐ Yes	□ No





Person ultimately re	esponsible t	or accoun
Name:		
Relation:		
Billing Address:		
CITY	STATE	ZIP
SSN:		
D.L.#:		
Work Phone#:		
Payment method:	☐ CASH	☐ Check
☐ Credit Card - Enter of	ard # above (i	f accepted)

	I hereby authorize assignment of
Initials	my insurance rights and benefits
directly	to the provider for services ren-
decad 1	fully understand I am calaly carnen.

dered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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 during diagnosis and treatment. I also authorize the provider and or managed care organization, 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 to the information I have provided.

Signature	Date / /
☐ Adult Patient ☐ Parent or Guardian ☐ Spouse	