

# PATIENT PERSONAL/CONFIDENTIAL DATA

Email \_\_\_\_\_ Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security No. \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ SS No. \_\_\_\_\_ No. of Children: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

How did you learn of this clinic? \_\_\_\_\_

Nearest relative not living with you? \_\_\_\_\_ Phone: \_\_\_\_\_

Who is responsible for payment?  Self  Spouse  Other \_\_\_\_\_

**PATIENT'S INSURANCE** **SPOUSE'S INSURANCE**

Name of Company: \_\_\_\_\_ Name of Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

ID & Group No. \_\_\_\_\_ ID & Group No. \_\_\_\_\_

Purpose of this appointment and list your complaints: \_\_\_\_\_

Date of illness: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Location: \_\_\_\_\_

How did the accident occur?  Auto  On the job  Other, \_\_\_\_\_

Please describe the circumstances and what makes the condition(s) better or worse: \_\_\_\_\_

Other Doctor seen for this condition: \_\_\_\_\_

Have you been treated by a Doctor for any health condition in the last year?  Yes  No

If yes, please describe: \_\_\_\_\_

## INSURANCE INFORMATION

*I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.*

Signature Physician: \_\_\_\_\_ Signature Patient: \_\_\_\_\_

## CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Rays studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: \_\_\_\_\_  
Parent's or Guardian's Signature: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CUURENTLY EXPERIENCING

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ No.: \_\_\_\_\_

MUSCULO SKELETAL SYSTEM	GENTO-URINARY SYSTEM	GASTRO-INTESTIONAL SYSTEM	CARDIO-VASCULAR RESPIRATORY
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Bladder trouble	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Pain over heart
<input type="checkbox"/> Pain between shoulders	<input type="checkbox"/> Scanty urination	<input type="checkbox"/> Difficult chewing	<input type="checkbox"/> Difficult breathing
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Difficult swallowing	<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Arm problems	<input type="checkbox"/> Discolored urine	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Coughing phlegm
<input type="checkbox"/> Leg problems		<input type="checkbox"/> Nausea	<input type="checkbox"/> Coughing blood
<input type="checkbox"/> Swollen joints	<b>FEMALE</b>	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Rapid heartbeat
<input type="checkbox"/> Painful joints		<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Blood pressure problem
<input type="checkbox"/> Stiff joints	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Sore muscles	<input type="checkbox"/> Vaginal bleeding	<input type="checkbox"/> Constipation	<input type="checkbox"/> Lung problems
<input type="checkbox"/> Walking problems	<input type="checkbox"/> Vaginal pain	<input type="checkbox"/> Black stool	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Spasms	<input type="checkbox"/> Breast pain	<input type="checkbox"/> Bloody stool	
<input type="checkbox"/> Broken bones	<input type="checkbox"/> Lumps on the breast	<input type="checkbox"/> Hemorrhoids	<b>EYE, EAR, NOSE, AND THROAT</b>
<input type="checkbox"/> Shoulder pain		<input type="checkbox"/> Liver trouble	
	<b>ARE YOU PREGNANT?</b>	<input type="checkbox"/> Gall bladder problems	<input type="checkbox"/> Eye strain
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Weight trouble	<input type="checkbox"/> Eye inflammation
			<input type="checkbox"/> Vision problems
	<b>HABITS</b>	<b>NERVOUS SYSTEM</b>	<input type="checkbox"/> Ear pain
			<input type="checkbox"/> Ear noises
	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Numbness	<input type="checkbox"/> Ear discharge
	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Loss of felling	<input type="checkbox"/> Hearing loss
	<input type="checkbox"/> Coffee or Tea	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Nose pain
	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nose bleeding
	<input type="checkbox"/> _____	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nose discharge
		<input type="checkbox"/> Headaches	<input type="checkbox"/> Difficult breathing through nose
		<input type="checkbox"/> Muscles jerking	<input type="checkbox"/> Sore gums
		<input type="checkbox"/> Convulsions	<input type="checkbox"/> Dental problems
		<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Sore mouth
		<input type="checkbox"/> Confusion	<input type="checkbox"/> Sore throat
		<input type="checkbox"/> Depression	<input type="checkbox"/> Hoarseness
		<input type="checkbox"/> Insomnia	<input type="checkbox"/> Difficult speech
			<input type="checkbox"/> Sinus
			<input type="checkbox"/> Allergy
			<input type="checkbox"/> Jaw pain

Patient's Signature: \_\_\_\_\_

-----DO NOT WRITE BELOW THIS LINE-----

\_\_\_\_\_

Patient Accepted?  Yes     No      Doctor's Signature: \_\_\_\_\_