

# WELCOME

## STEP ONE

### ABOUT YOU:

Today's Date \_\_\_\_\_

File # \_\_\_\_\_

#### **PATIENT NAME** \_\_\_\_\_

What you Prefer to be Called \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

#### **REFERRED BY** \_\_\_\_\_

Employer \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address \_\_\_\_\_

Occupation \_\_\_\_\_

Status: \_\_\_ Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed

Spouse's Name \_\_\_\_\_

Children: \_\_\_ No \_\_\_ Yes, How Many \_\_\_\_\_

## STEP TWO

### INSURANCE INFO:

Company Name \_\_\_\_\_ ID# \_\_\_\_\_

Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's Employer \_\_\_\_\_

## **STEP THREE** **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 and its location: \_\_\_\_\_

When did this 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, explain: \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_ Yes \_\_\_ No

If so, explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition? \_\_\_ Yes \_\_\_ No

If so, where? \_\_\_\_\_

Have you ever been treated by a Chiropractic before? \_\_\_ Yes \_\_\_ No

If so, whom? \_\_\_\_\_ Phone # \_\_\_\_\_

## **STEP FOUR** **IN THE EVENT OF EMERGENCY:**

Who Should we contact? \_\_\_\_\_

Relation \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ Phone # \_\_\_\_\_

## **STEP FIVE:** **HEALTH HISTORY**

**Are you taking any of the following medications?**

*\_\_Nerve Pills \_\_Pain Killers (incl. aspirin) \_\_Muscle Relaxers \_\_Stimulants  
\_\_Blood Thinners \_\_Tranquilizers \_\_Insulin \_\_Other(s)\_\_\_\_\_*

**Do you have or ever had any of the following diseases or conditions?**

- |                                |                             |                       |
|--------------------------------|-----------------------------|-----------------------|
| Y N Heart Attach/Stroke        | Y N Heart Surg./Pacemaker   | Y N Heart Murmur      |
| Y N Congenital Heart Defect    | 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 Cancer            |
| Y N Frequent Neck Pain         | Y N Emphysema/Glaucoma      | Y N Anemia            |
| Y N High/Low Blood Pressure    | Y N Psychiatric Problems    | Y N Rheumatic Fever   |
| Y N Severe/Frequent Headaches  | Y N Kidney Problems         | Y N Ulcers/Colitis    |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems          | Y N Asthma            |
| Y N Diabetes/Tuberculosis      | Y N Difficulty Breathing    | Y N Chemotherapy      |
| Y N Lower Back Problems        | Y N Artificial Bones/Joints | Y N Arthritis         |

**Please list any other serious medical condition(s) you have or ever had:**

*Please list anything that you may be allergic to: \_\_\_\_\_*

*List previous surgeries/treatments with dates: \_\_\_\_\_*

*List any **past** serious accidents with dates \_\_\_\_\_*

*Family Health History \_\_\_\_\_*

**Do you: Take Supplements/Vitamins \_\_Yes \_\_No      Exercise? \_\_Yes \_\_No**

*Are you on a special diet? \_\_Yes \_\_No      How Long? \_\_\_\_\_*

*Are you wearing: \_\_Heel lifts \_\_Sole lifts \_\_Inner Soles \_\_Arch supports*

*What is the age of your mattress? \_\_\_\_\_ Is it comfortable? \_\_Yes \_\_No*

**For women:** *Are you taking Birth Control? \_\_Yes \_\_No*

*Are you Pregnant? \_\_No \_\_Yes/How Long? \_\_\_\_\_ Nursing? \_\_Yes \_\_No*

**STEP SIX**  
**ACCOUNT INFO:**

***Person ultimately responsible for account***

Name \_\_\_\_\_

Relation \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

SSN \_\_\_\_\_

Work Phone \_\_\_\_\_

\_\_\_\_\_ *I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. 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 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** \_\_\_\_\_