It is the policy of this office to collect payments or co-pays at the time of service. All who have not met their insurance deductibles are expected to pay for services at the time of treatment. Your insurance company will be billed as a courtesy regardless of your deductible. Thank you.

PATIENT INFORMATION

Patient's Name & Address _____

Cell Phone: _____
Home Phone: _____
Patient's SSN: _____
Patient's Birthdate: _____
Patient's Sex: ___ M ___ F

Emergency Contact: _____
Patient's Relationship to the Above Contact: _____
Contact's Phone: _____

Patient's Employer: _____
Employer's Address: _____
Patient's Work Phone: _____

Marital Status: Single Married Divorced Separated Widowed Other

Employ Status: 1 - Full 2 - Part 3 - Not Emp 4 - Self 5 - Retired 6 - Military

Student?: NO Full-Time Part-Time

Referring Doctor: _____
Doctor's Phone: _____

HOW DID YOU LEARN OF THIS OFFICE?

Please supply us with your health insurance, workmen's compensation, or motor vehicle accident information. If we do not receive this information we will bill you directly.

HEALTH INSURANCE INFORMATION

Primary Health Insurance Company's Name and Address: _____

Telephone Number: _____

Insurance Effective Dates: _____ through _____

Please circle type of payor or policy:

GP - Group Policy MP - Medicare
IP - Individual Policy PP - Personal Pay
LD - L/T Disability OT - Other

Insured's Name: _____ Sex: M F Insured's Birthdate: _____

Policy / Claim Number: _____ Insured's Emp Status: 1 - Full 2 - Part 3 - Not Emp 4 - Self 5 - Retired 6 - Military

Patient's Relationship to the Insured: 1 - Self 2 - Spouse 3 - Child 4 - Other _____ 7 - Other: _____

Insured's Group Name / Number (if group policy): _____

Insured Employer (if insurance is from Employer): _____

IF YOU WERE INJURED AT WORK

Name & Address of Workmen's Compensation Insurance Carrier: _____

Claim Number: _____ Phone Number: _____

Person to contact to verify injury: _____

Patient's Name: _____

Chiropractic Problem: (Describe)

_____

_____

How long have you had this condition?	Is it getting worse? ☐ Yes ☐ No	Does it bother you: ☐ Work ☐ Other ☐ Sleep (Specify)
What seemed to be the initial cause?		
Have you seen a chiropractor before? ☐ Yes ☐ No	If yes, how long ago?	For what reason?
Are you under the care of a physician? ☐ Yes ☐ No	If yes, for what?	
Have you been hospitalized in the last 5 years? ☐ Yes ☐ No	For major surgery? ☐ Yes ☐ No	For serious injury? ☐ Yes ☐ No / Have you had any mental or emotional disorders? ☐ Yes ☐ No / If yes, when?
Drugs you now take: ☐ Birth control pills ☐ Tranquilizers ☐ Painkillers ☐ Others		
Do you wear: ☐ Heel lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐ Negative Heels ☐ Platform Shoes		
Age of your mattress:	☐ Comfortable ☐ Uncomfortable	Do you use a bedboard? ☐ Yes ☐ No
How is most of your daytime spent?: ☐ Standing ☐ Sitting ☐ Walking ☐ Other (specify)		

PUT AN X IN FRONT OF THOSE SYMPTOMS YOU NOW HAVE:

- ☐ Headache
- ☐ Neck Pain
- ☐ Pain between shoulder blades
- ☐ Low back pain
- ☐ Allergies
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Nausea
- ☐ Vomiting
- ☐ Bursitis
- ☐ Fever
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Gain of Weight
- ☐ Nervousness / Depression
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Constipation
- ☐ Diarrhea
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Heart / Circulatory Disease

DO YOU HAVE PAIN OR NUMBNESS IN:

- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Tailbone

HAVE YOU EVER:

	Yes	No	If yes, explain briefly
Had a broken bone?	☐	☐	
Been hospitalized?	☐	☐	
Had strains or sprains?	☐	☐	
Had a cane, crutch or other support?	☐	☐	
Been struck unconscious?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	

DO YOU:

	YES	NO	
Take minerals, herbs or vitamins?	☐	☐	
Think you needs minerals, herbs or vitamins?	☐	☐	
Have any drug allergy?	☐	☐	

HABITS

	None	Light	Med.	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐

WHEN DID YOU LAST HAVE:

	None	6-12 mo	1-5 mo	Longer
Spinal x-ray	☐	☐	☐	☐
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐

FEMALE ONLY: Are you pregnant? ☐ Yes ☐ No

If yes, how long? _____

Number of Children: _____

Periods Irregular? ☐ Yes ☐ No