Welcome

To

Chiropractic Family Health Center

1

ABOUT YOU

Today's Date: _____ / _____ / _____ File #: _____

Name: _____

What You Prefer to Be Called: _____ ❑ Male ❑ Female

Birthdate: _____ / _____ / _____ Age: _____ SS#_____

Home Address: _____

_____
City State Zip

Home Phone #: _____

Other Phone #: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
City State Zip

Occupation: _____ Work Phone: _____

Marital Status: ❑ Singe ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Number of Children: _____

Spouse's Name: _____ Spouse's Work Phone:_____
(or next of kin)

Medical Physician's Name: _____

2

INSURANCE INFORMATION

Company Name: _____

Address: _____

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relationship: _____ Date of Birth: _____ / ____ / _____

Insured's Employer: _____

Please inform front desk of second insurance source.

REASON FOR VISIT

Have you had previous chiropractic care? _____

What is your major complaint? _____

Other complaints: _____

How did condition develop? _____

Date of onset: _____ Have you had same or similar problems in the past: _____

Is this condition getting worse? ❑ yes ❑ no ❑ constant ❑ comes & goes

How long has it been since you really felt good? _____

What aggravates condition? _____ Does anything offer relief? _____

How would you describe discomfort? ❑ sharp ❑ dull ❑ achy ❑ throbbing

What percent of time does this condition bother you? ❑ 0% ❑ 25% ❑ 50% ❑ 75% ❑ 100%

How would you rate the level of discomfort on a scale of 0-10 (0=no pain 10=extreme pain)? _____

Others who have treated you for this condition: _____

3

4

HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Have you ever had any of the following disease/medical condition(s)?

Y	N	Heart Attack/Stroke	Y	N	Psychiatric Problems
Y	N	Congenital Heart Defects	Y	N	Kidney Problems
Y	N	Alcohol/Drug Abuse	Y	N	Sinus Problems
Y	N	HIV+/AIDS	Y	N	Difficulty Breathing
Y	N	Frequent Neck Pain	Y	N	Artificial Bones/Joints
Y	N	High/Low Blood Pressure	Y	N	Heart Murmur
Y	N	Severe/Frequent Headaches	Y	N	Artificial Valves
Y	N	Fainting/Seizures/Epilepsy	Y	N	Hepatitis
Y	N	Diabetes/Tuberculosis	Y	N	Cancer
Y	N	Lower Back Pain	Y	N	Anemia
Y	N	Heart Surg./Pacemaker	Y	N	Rheumatic Fever
Y	N	Mitral Valve Prolapse	Y	N	Ulcers/Colitis
Y	N	Venereal Disease	Y	N	Asthma
Y	N	Shingles	Y	N	Chemotherapy
Y	N	Emphysema/Glaucoma	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 all previous surgeries/treatments with dates: _____

_____

List any and all accidents with dates: _____

_____

Do you exercise regularly? ❑ No ❑ Yes/how much? ____ How long? _____

Do you smoke? ❑ No ❑ Yes/how much? _____ How long? _____

Are you wearing? ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? _____ Is it comfortable? ❑ No ❑ Yes

For women: Are you taking birth control? ❑ No ❑ Yes

Are you pregnant? ❑ No ❑ Yes/How long? _____ Nursing? ❑ No ❑ Yes

5

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____

Relationship: _____

Billing Address: _____

_____

S.S. #: _____

D.L. #: _____

Work Phone #: _____

Payment method: ❑ Cash ❑ Check ❑ Credit Card

CC #: (if accepted): _____ _____/_____

❑ I hereby authorize assignment of my insurance right and benefits directly to the provider for services rendered (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 any 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 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 in my medical status.

Signature _____ Date _____ / _____ / _____