

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Email \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## Reason for Visit

Have you ever seen a chiropractor?  Yes  No If yes, when and why? \_\_\_\_\_

Your reason for *this* visit: \_\_\_\_\_

Please describe your pain and its location: \_\_\_\_\_

When did symptoms begin (date)? \_\_\_\_\_ Have you had similar conditions in the past? \_\_\_\_\_

Is pain getting:  Worse  Better  Same  Comes and goes How often do you have this pain? \_\_\_\_\_

Have you been treated by a medical physician for this condition? \_\_\_\_\_

If so, when and where? \_\_\_\_\_

Activities or movements that are difficult/painful to perform:  Sitting  Walking  Bending  Lying down  Lifting

Type of pain:  Sharp  Dull  Throbbing  Aching  Burning  Tingling  Numbness  Cramping

Stiffness  Swelling  Other \_\_\_\_\_

Is pain interfering with:  Work  Sleep  Daily Routine  Recreation

Please complete both sides.

## Health History

Please list any medication (including pain killers) you are taking: \_\_\_\_\_

Please list any serious injuries you have had in the last 10 years:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other Serious Injuries	_____	_____

Women: Are you pregnant?  Y  N If so, how far along? \_\_\_\_\_ Nursing  Y  N

## Medical Conditions

Check (✓) yes or no whether you have had or currently have any of the following medical conditions?

- |                                                                                      |                                                                                    |                                                                                     |                                                                                      |
|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack/Stroke            | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                    | <input type="checkbox"/> Y <input type="checkbox"/> N Ringing in Ears               | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect        | <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Neck Pain           | <input type="checkbox"/> Y <input type="checkbox"/> N Severe/<br>Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Gout                           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse             | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain                     | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes/Tuberculosis         | <input type="checkbox"/> Y <input type="checkbox"/> N Numbness, where?<br>_____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting/<br>Seizures/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Wrist Pain                   | <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness                     | <input type="checkbox"/> Y <input type="checkbox"/> N Tingling, where?<br>_____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       | <input type="checkbox"/> Y <input type="checkbox"/> N Shoulder Pain                | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema/Glaucoma            | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Spasms,<br>where? _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems           | <input type="checkbox"/> Y <input type="checkbox"/> N Arm Pain                     | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems               |                                                                                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing           | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Pain                     | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints       |                                                                                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                      | <input type="checkbox"/> Y <input type="checkbox"/> N Lower Back Problems          | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                        |                                                                                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                         | <input type="checkbox"/> Y <input type="checkbox"/> N Severe/<br>Frequent Earaches | <input type="checkbox"/> Y <input type="checkbox"/> N HIV Positive/AIDS             |                                                                                      |

## Personal Habits

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_