



TODAY'S DATE _____

FILE NO. _____

PATIENT DATA

NAME _____
LAST FIRST MIDDLE

WHAT DO YOU PREFER TO BE CALLED _____ **REFERRAL SOURCE** _____

HOME ADDRESS _____
STREET CITY / STATE ZIP

HOME PHONE () - _____ **DATE OF BIRTH** _____

CELL PHONE () - _____ **MALE** **FEMALE**

E-MAIL ADDRESS _____

ARE YOU OVER 18 YEARS OF AGE? **YES** **NO** (PARENTAL AUTHORIZATION REQUIRED SEE BACK OF FORM)

MARITAL STATUS **SINGLE** **MARRIED** **DIVORCED** **SEPARATED** **WIDOWED**

EMPLOYED BY _____ **OCCUPATION** _____

BUSINESS ADDRESS _____ **HOW LONG?** _____

SPOUSE'S NAME _____ **OCCUPATION** _____

EMPLOYED BY _____ **WORK PHONE** _____

EMERGENCY CONTACT IF OTHER THAN SPOUSE _____ **PHONE** _____

HEALTH HISTORY (HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS)

Yes	No	CONDITION	Yes	No	CONDITION	Yes	No	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOL / DRUG ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA / GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	POLIO
<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING / SEIZURES / EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT NECK PAIN	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER
<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL BONES / JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK / STROKE	<input type="checkbox"/>	<input type="checkbox"/>	SEVERE / FREQUENT HEADACHES
<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL VALVE	<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	SHINGLES
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY / PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	SINUS PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	HEMORRHOIDS	<input type="checkbox"/>	<input type="checkbox"/>	TRANSMANDIBLE JOINT DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	CARPAL TUNNEL	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	ULCERATIVE COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY	<input type="checkbox"/>	<input type="checkbox"/>	HIGH / LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS / COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DEFECT	<input type="checkbox"/>	<input type="checkbox"/>	INTESTINAL PERFORATION	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR ANEURISM
<input type="checkbox"/>	<input type="checkbox"/>	CROHN'S DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES / TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS	OTHER _____		
<input type="checkbox"/>	<input type="checkbox"/>	DIALYSIS TREATMENTS	<input type="checkbox"/>	<input type="checkbox"/>	LOWER BACK PROBLEMS	_____		
<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	_____		
<input type="checkbox"/>	<input type="checkbox"/>	DIGESTIVE DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	MULTIPLE SCLEROSIS	_____		
<input type="checkbox"/>	<input type="checkbox"/>	DIVERTICULITIS	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULAR DYSTROPHY	_____		
<input type="checkbox"/>	<input type="checkbox"/>	DIZZINESS/VERTIGO	<input type="checkbox"/>	<input type="checkbox"/>	NEURITIS	_____		
SMOKING <input type="checkbox"/> Yes <input type="checkbox"/> No			ALCOHOL <input type="checkbox"/> Yes <input type="checkbox"/> No					
IF "YES" HOW MUCH? _____			IF "YES" HOW MUCH? _____					

WOMEN ONLY

ARE YOU PREGNANT? Yes No

ARE YOU NURSING? Yes No

(Please turn page over to complete back of form)



PURPOSE OF VISIT

REASON FOR THIS VISIT: WORK INJURY/ILLNESS SPORTS INJURY AUTO ACCIDENT OTHER

DESCRIBE: _____

DATE OF INJURY _____ NUMBER OF DAYS MISSED FROM WORK? _____

HAVE YOU BEEN TREATED FOR THIS INJURY BEFORE? YES NO IF "YES", PLEASE EXPLAIN: _____

HAVE YOU HAD X-RAYS TAKEN FOR THE AREA REQUIRING TREATMENT: NO YES

IF "YES", WHEN AND WHAT AREAS WERE X-RAYED? _____

INFORMED CONSENT

To ensure you are fully informed regarding your care; to that purpose we are providing the following information. We also invite and encourage you to discuss with us any questions regarding your treatment and/or our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- Our practice objective is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. A vertebral subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which cause an alteration of the nerve function and interference to the transmission of mental impulses.
- Various modes of physical therapy and diagnostics may be utilized by the doctor in order to determine the best course of treatment. Care and treatment may be delivered by our licensed doctors of chiropractic and /or the associates working at the facility.
- I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to dislocations, strains or disk impairment. I understand the doctor cannot anticipate nor explain all risks, and I wish to rely on the doctor to exercise judgment during the course of the procedure based on known facts and my best interest.
- Office 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 an account is submitted for insurance payment and payment is discounted or denied, I understand I am fully responsible for all outstanding charges. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting on my account. I also understand that if I suspend or terminate care and treatment, any fees for services will be immediately due and payable.
- 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 that if I do not give at least 24-hours notice when canceling an appointment, I may be responsible for a cancellation charge, not to exceed \$35, to cover any lost costs and wages for my therapist.
- 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.
- I have read or have had read to me the above consent and I accept care on this basis.

SIGNATURE _____

DATE _____

PARENT OR GUARDIAN AUTHORIZATION: [ONLY IF PATIENT IS UNDER 18 YEARS OF AGE]

▪ I, _____ being the parent/legal guardian of _____
[PLEASE PRINT YOUR NAME] [PLEASE PRINT NAME OF CHILD OR WARD]
 have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

SIGNATURE _____

DATE _____