



Welcome

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS/HIC/Patient ID# _____
First Middle Initial Last
Address _____ City _____ State _____ Zip _____
Sex: ☐ Female ☐ Male Birthdate _____ E-mail _____
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference
☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Work Phone (____) _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone (____) _____

Responsible Party

Name of person responsible for this account _____
Relationship to patient _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work Phone (____) _____

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date employed _____
Name of employer _____ Work Phone (____) _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone (____) _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____
DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date employed _____
Name of employer _____ Work Phone (____) _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____



Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

Health History

Check only those conditions which are applicable:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |

Dates of last exams _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? ☐ No ☐ Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient