



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:

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