

----INSURANCE INFORMATION----

Primary Insurance Company: _____

Address: _____
STREET CITY STATE ZIP

Phone: (____) _____

Insured's ID #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____ DOB: _____

Secondary Insurance Company: _____

Address: _____
STREET CITY STATE ZIP

Phone: (____) _____

Insured's ID #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____ DOB: _____

----REASON FOR VISIT----

Emergency: _____ New Injury: _____ Old Injury: _____ Chronic Pain: _____ Wellness: _____

Are you in pain? Yes ___ No ___

Rate your pain on a scale from 1-10 (1 being slight discomfort, 10 being intense pain) _____

Did you injury occur during: Work ___ Sports/Play ___ Auto Accident ___ Routine Activity ___

When did your injury occur? ____/____/____ Where did your injury occur? _____

Please explain what happened: _____

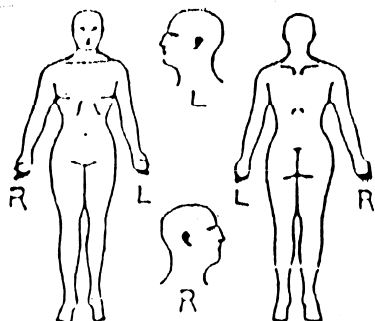
Is your condition getting worse, constant, or comes and goes? _____

Is your condition interfering with your: Work _____? Sleep _____? or Daily routine _____?

If so, how: _____

Has this or something similar happened in the past? Please explain. _____

Please circle the affected areas:



Have you seen a Medical Physician for this condition? If so where: _____

Have you ever been treated by a Chiropractor? _____

Clinic/Doctor's Name _____

Phone #: _____

---HEALTH HISTORY---

Please list any medications you are taking: _____

Please list any diseases, medical conditions or procedures? _____

List any past serious accidents with dates: _____

Please list anything you may be allergic to: _____

Important Family Health History: _____

Do you take Supplements or Vitamins? Yes ___ No ___ Do you exercise? Yes ___ No ___

Do you smoke? Yes ___ NO ___ How much? _____ How long? _____

Do you wear shoe lifts, inner soles, arch supports? _____

Are you dieting? _____ Since when? _____

For woman: Are you taking Birth Control? _____

Are you nursing? ___ Are you pregnant? _____ How many weeks? _____

- We invite you to discuss 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 legal fees, collection agency fees, interest charges and any other 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 it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ____/____/____