

PERSONAL HISTORY

Date _____

Please complete this form to the best of your ability. If you need help our receptionist will be glad to assist you!

Full Name _____ Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Cell _____

E-mail _____ Sex: M F Single / Separated / Married / Widowed / Divorced

Birth _____ Social Security# _____ How did you hear about our office _____

Employed / Student / Other Employer _____ Type of work _____

Emergency Contact _____ Phone _____ Relationship _____

Type of Payment you plan to use (circle): **Insurance Cash Credit Card Medicare Other**

Your Family

Spouse's Name _____ Date Of Birth _____ Social Security# _____

Name and age of children _____

Accident Injury Information

Are your present problems due to an accident-injury? _____ Date _____

Type of accident-injury (circle): **Auto On-the-Job Sports Military Household Slip/Fall Personal Other**

Name of Attorney handling your case _____ Phone _____

Insurance Information (IF YOU HAVE BEEN IN AN AUTO ACCIDENT; circle Auto and proceed to next section.)

Type of Insurance you plan to use to help pay your account (circle): **Auto Health Medicare On-the Job Other**

Insurance company _____ Phone _____

Insured's Name _____ Insured's DOB _____

Your Injury, Illness, or Condition

What is your injury, illness or condition _____

Names of other doctors seen for this condition _____

Type of previous treatment and/or surgery for this condition _____

Results of previous treatment (circle): **Good Fair Poor Other** _____

Medication you are presently taking _____

Do you suffer from any condition other than that which you are now consulting us? _____

Have you been treated for any health condition in the last year? Y _____ N _____ If YES please explain _____

Previous Chiropractic Care

Name of chiropractor _____ Condition treated _____

Results of treatment _____ Date of last visit _____

Health Problems

CIRCLE conditions you have **NOW** and **UNDERLINE** conditions you have had **PREVIOUSLY**:

- | | | | |
|-------------------------------|-----------------------|---------------------|---------------------|
| Low Back Pain | Fractured Bones | Spinal Taps | Fainting |
| Arm Pain | Dislocation | Scoliosis | Birth Defects |
| Headaches | Joint Replacement | Diabetes | Osteoporosis |
| Neck Pain | Metal Screws/implants | High Blood Pressure | Cancer |
| Pain Between Shoulders | Cervical Whiplash | Stroke | Tumor |
| Leg Pain | Electronic Implant | Aneurysm | Cyst |
| Cold/Tingling Fingers or Toes | Pacemaker | Convulsions | Ear Infections |
| Numbness | Ruptured Spinal Disc | Seizures | Birth Complications |
| Allergies | Slipped spinal disc | Memory Lapse | Asthma |
| Loss of Sleep | Pinched Nerve | Dizziness | Bed Wetting |
| Stomach/Digestive Problems | Spinal Surgery | Concussion | Heart Disease |
| Walking problems | Spinal Infections | Knocked Unconscious | Fever |

Are you Pregnant? Y _____ N _____ Other serious illness _____

Criteria to be accepted as a Patient

Unfortunately, we cannot accept everyone as a patient so patients are accepted on a necessity and patient commitment criteria.

1. We must feel your condition is serious enough to necessitate treatment
2. We must feel we will have very favorable results from your treatment.
3. In the event you cannot make an appointment you agree to call in advance to reschedule.

Treatment Authorization

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that statements made in any video presentation are made by non-doctors. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

Patient's signature (x) _____ Date _____

Consent To Treat a Minor

I (we) being the parents, guardian or custodian of the minor being _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature _____ Date _____

Witness _____ Date _____