

Introduction and History

Date: _____

Name:	Date of birth (Month/Day/Year):
Home Address and Phone Number:	Employer and Work Phone Number:
E-Mail:	Occupation:
Cell Phone:	Social Security Number
Family Medical Doctor:	Referred by (please include person's name): <input type="checkbox"/> Friend/Family <input type="checkbox"/> M.D. / D.C. <input type="checkbox"/> Internet/Add
Have you had Chiropractic care before? If so, when and by whom?	Children's Name and Ages:
Spouse's Name and Occupation:	Hobbies:
Please circle sex: Male Female	

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible Chiropractic care, we will need to discover any '**stresses**' that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting this office

Wellness / Prevention Care - *I wish to continue my Chiropractic Wellness Care.* Just answer the following questions that apply.

Please describe your current problem, including the effect it has had on your life:

Please describe the character of your pain (check all that apply)

Sharp/Stabbing	Sharp/Dull	Achy	Dull	Soreness	Weakness
Throbbing/Gnawing	Numbness	Shooting	Gripping/Constricting		
Burning	Tingling	Other: _____			

PLEASE TURN OVER g

A word about our financial policies:

Our recommendations are based solely on the difficulty of your case and are never influenced by your level of insurance coverage.

All charges will be discussed with you and agreed upon, before any service will be provided.

Payment is expected on the day services are rendered unless other arrangements have already been agreed upon.

Practice members who are committed to their care programs will never be denied treatment. We have many programs which make our care affordable to those who are committed to achieving optimal health.

PLEASE ANSWER ALL QUESTIONS! Please print clearly.

1. Who is responsible for this account? _____

2. Relationship to practice member

3. Do you have insurance coverage? -

a. If yes, subscriber's name

b. Date of birth _____ c. Social Security number

4. Do you have secondary coverage?

a. If yes, subscriber's name

b. Date of birth _____ c. Social Security number

5. **How would you like to pay for your 1st visit?** Please circle one

- a. Cash b. Check c. Credit Card
d. Debit Card w/Visa,MC, Discover, AmEx.

PATIENT'S SIGNATURE _____

DATE _____