General Information:

Dear Patient,
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Name_____Social Security #_____

Address_____City_____State_____Zip_____

Primary Telephone ( )_____Alternate Number ( )_____

Place of Employment/Occupation_____Sex(M)___(F)_____ Birth Date_____

E-Mail Address_____ Marital Status: M S W D Spouse Name & DOB:_____

Number of Children_____Age of Children_____Spouse Work Telephone( )_____

Nearest Relative_____Telephone Number ( ) _____

How did you hear about our office?_____

Health Information:

What is your major complaint?_____

Other complaint's?_____

_____

How long have you had this condition?_____

What activities aggravate your condition?_____

Is this condition getting progressively worse? Yes____No____Constant___Comes and Goes_____

Is this condition interfering with your Work_____Sleep_____Daily Routine_____Other?_____

How long has it been since you felt good? _____

List other doctors who have treated this condition_____

_____

List surgical operations and years?_____

Age of Matress_____Comfortable_____Uncomfortable_____

Are you wearing: Heel Lifts_____Sole Lifts____Inner Soles_____Arch Supports_____

Have you been in an auto accident? Past year_____Past 5 Years_____Over 5 years_____

Describe_____

_____

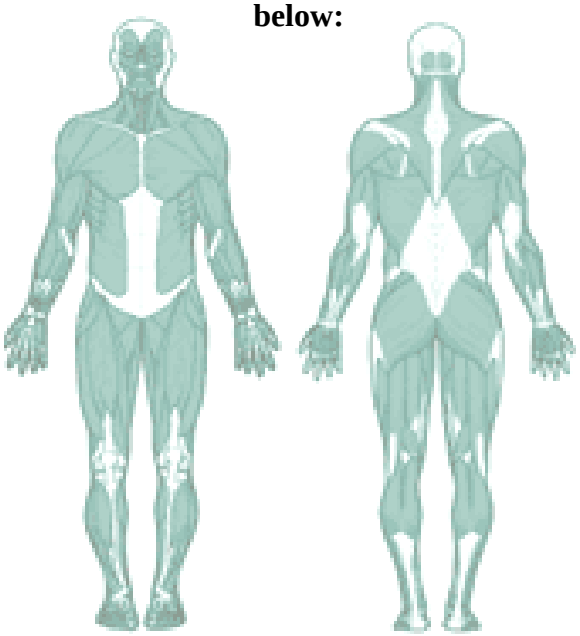
_____

_____

Women: To the best of your knowledge are you pregnant? Yes___ No____

(Please see back of page)

Please mark areas of pain on the figures below:



CIRCLE BELOW ALL THAT APPLY:

1. Dizziness
2. Backaches
3. Heart Trouble
4. Diabetes
5. Arthritis
6. Headaches
7. Asthma
8. Neuritis
9. Digestive Disorders
10. Nervousness
11. Sinus Trouble
12. Neck Pain

Insurance Information:

Is your condition due to an auto accident or job related injury? Yes____No ___
Do you have Health Insurance? Yes____ No _____

If yes, Name of Company_____

Policy# _____Group#_____

Are you covered by Medicare? Yes_____ No_____If yes, Medicare policy # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Further more, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature_____Date_____

Guardian or Spouse's Signature_____SS#_____

Doctor's Signature_____

Credit Card Information

All accounts not paid within 30 days will automatically be put through on your credit card.

Master Card__ Visa___Amex___Card #_____Exp. Date_____

Cardholder's Signature_____

Family Health History:

IF YOU OR ANY MEMBER OR YOUR FAMILY HAS EXPERIENCED ANY OF THE FOLLOWING PLEASE ✓ IT OFF IN THE APPROPRIATE SPACE.

Condition	Self	Spouse	Mother	Father	Child	Child
Headache						
Sinus Troubles						
Allergies						
Eye Troubles						
Earaches						
Hearing Dysfunction						
Skin Disorders						
Throat Problems						
Neck/Shoulder Pain						
Tonsillitis						
Frequent Colds						
Bursitis						
Thyroid Disorders						
Asthma						
Breathing Problems						
Pain in the arms or hands						
Heart Dysfunction						
Chest Pain						
Shingles						
Liver Problems						
Anemia						
Stomach Problems						
Diabetes						
Digestive Problems						
Colitis						
Hernias						
Appendicitis						
Menstrual Disorders						
Impotence						
Urination Problems						
Backaches						
Weakness/Cramping in the legs						
Hemorrhoids						