WELCOME

Please fill out this form completely. If you have questions we'll be glad to help you.

Legal Name_____ _____SSN:_____
Last Name *First Name* *Initial* *Name I like to be called*

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell _____ Work _____

Best time to call (*Circle one*) **AM PM** Call me at (*Circle one*) **Work Home Cell** Ok to leave a message (*Check if YES*) ____

Sex ___M ___F Age_____ Birthdate_____/_____/_____ ___Single ___Married ___Widowed ___Separated ___Divorced

Student _____ Occupation_____ Employer_____

Business address_____Emergency Contact_____Phone_____

Primary Care Physician_____Phone_____

Would you like to receive our newsletter or special offers by email? _____Y _____N Email_____

How did you hear about us? Referral from _____Internet____ Yellow Page_____ Ad _____ Other _____
PLEASE PRINT

Circle services you want: Chiropractic Nutrition Rejuvenation Soft Tissue Physical Therapy Massage Acupuncture

Insurance Information – Complete this section if you are using insurance and NOT the policy holder

Person Responsible for This Account_____
Last Name *First Name* *Initial*

Relation to Patient_____ Birthdate_____/_____/_____ SSN_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell _____Email_____

Guarantors Employer_____Occupation_____

Business Address_____Business Phone_____

Primary Insurance Company_____ Secondary Insurance Company_____

Reason for Your Visit Today

I am interested in the following: ____**Chiropractic Care** ____**General Massage** ____**Medical Massage** ____ **Acupuncture** ____**Nutrition**

What is your health concern today?_____

Please describe your pain and its location_____

When did it first start? (date)_____Have you ever had this or a similar problem before? _____Y _____N

If yes, when, where and what were the results?_____

Is the pain getting: _____ Better _____ Worse _____ Same _____ Comes and Goes How often you get this pain?_____ Constant (100% of the time _____Frequent (75% of the time) _____ Infrequent (50% of the time) _____ Seldom (25 % of the time.

Have you been treated for this condition? _____ N _____ Y Who, when and where?_____

Have you ever had chiropractic care? _____N _____Y Doctors name and address _____

Activities or movements that are difficult or painful: ___ Sitting ___ Walking ___ Bending ___ Lying down ___ Lifting

Type of pain: ___ Sharp ___ Dull ___ Throbbing ___ Aching ___ Burning ___ Tingling ___ Numbness ___ Cramping ___ Stiffness ___ Swelling

Has this pain affected your life in anyway? ___ N ___ Y ___ Work ___ Sleep ___ Daily Routine ___ Recreation

Please list the medications you are taking: _____

Medical History Past & Present

Please list injuries you have had in the past 10 years include car accidents, slips, falls etc:

	Description	Date
Falls / Injuries	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Auto	_____	_____
Other	_____	_____

Check (√) yes or no whether you have had or currently have any of the following medical conditions

Heart and Lungs
_____Y _____N Chest Pain
_____Y _____N Coughing
_____Y _____N Sputum production
_____Y _____N Chest Noises
_____Y _____N Difficulty Breathing
_____ Y _____N Heart Attack/Stroke
_____Y _____N Congenital Heart Defect
_____Y _____N Heart Disease
_____Y _____N High Blood Pressure
_____Y _____N Cancer
_____Y _____N Epilepsy/Seizures
_____Y _____N Shingles
_____Y _____N Allergies

Abdominal
_____Y _____N Pain
_____Y _____N Gas
_____Y _____N Burning
_____Y _____N Nausea/Vomiting
_____Y _____N Diarrhea/Constipation

General
_____Y _____N Gout
_____Y _____N Ulcers
_____Y _____N Abdominal Pain
_____Y _____N Difficulty Breathing
_____Y _____N Hepatitis
_____Y _____N Anemia
_____Y _____N Arthritis
_____Y _____N Kidney Disease
_____Y _____N Diabetes
_____Y _____N Liver Problems
_____Y _____N Bleeding Tendency
_____Y _____N Tuberculosis (TB)
_____Y _____N Cancer
_____Y _____N Glaucoma

Muscles / Joints
_____Y _____N Back Problem
_____Y _____N Neck Problem
_____Y _____N Broken Bones
_____Y _____N Jaw Pain
_____Y _____N Wrist Pain
_____Y _____N Shoulder Pain
_____Y _____N Arm Pain/Hand Pain
_____Y _____N Leg Pain/Ankle Pain
_____Y _____N Hip Pain
_____Y _____N Knee Pain
_____Y _____N P Foot Condition
_____Y _____N Muscle Pain
_____Y _____N Muscle Cramps
_____Y _____N Muscle Weakness
_____Y _____N Joint Pain
_____Y _____N Joint Stiffness
_____Y _____N Grinding/Popping
_____Y _____N Loss of Flexibility

WOMEN ONLY
Menstrual/Obstetrical
_____Y _____N Cramps
_____Y _____N Menopause
_____Y _____N Hysterectomy
_____Y _____N Estrogen Medication
_____ Number of Pregnancies
_____ Number of Children:
Are you pregnant? ___Y ___N
Due Date_____
Breastfeeding? ___Y ___ N
_____Y _____N Difficult Pregnancies
_____Y _____N Difficult Deliveries
_____Y _____N Breast Tenderness
_____Y _____N Breast Lumps

MEN ONLY
If you are over 50 when was the most recent prostate exam? _____

Eyes
_____Y _____N Pain
_____Y _____N Spots
_____Y _____N Double Vision

Ears
_____Y _____N Pain
_____Y _____N Ringing/Noises
_____Y _____N Hearing Loss
_____Y _____N Loss of Balance

Head
_____Y _____N Fainting
_____Y _____N Trauma
_____Y _____N Dizziness

Nervous System:
_____Y _____N Numbness
_____Y _____N Tingling (pins & needles)
_____Y _____N Nervousness
_____Y _____N Coordination/balance problems
_____Y _____N Convulsions

Mental / Emotional
_____Y _____N Nervous Condition
_____Y _____N Alcohol/Drug Abuse
_____Y _____N Psychiatric Problems

Personal – Check best answer
Alcohol _____ Heavy _____ Light _____ None
Coffee _____ Heavy _____ Light _____ None
Tobacco _____Y _____N What _____
_____ Heavy _____ Light _____ None
Recreational Drugs_____Y _____N
_____ Heavy_____ Light _____ None
Exercise How often?_____
Sleep How many Hrs.?_____
Appetite _____ Good _____ Bad _____ Other

We respect your privacy and follow all HIPPA requirements, however this office uses open therapy bays so you may not have 100% privacy at all times. If you want to meet with the doctor in a closed room please ask. My signature indicates that a copy of the HIPPA Privacy Notice has been made available to me. In addition, I give permission to share my health information with:

_____ _____ Date _____
Their Name Relationship

_____ _____
Print Your Name Signature or Legal Representative

Policies – *Please read and initial ALL*

Financial You are responsible for your bill. If you need itemized statements please ask. Payment is due in full at the time services are rendered. We accept cash, check and most major credit cards. Administrative fees in addition to up to 15% monthly collection fee may be added to unpaid bills. _____**initial**

Insurance: If you have health insurance please provide current insurance cards for us to copy. If you have a secondary health insurance policy please let us know. We file insurance as a courtesy to you and will verify your benefits. *Upon verification your insurance company states that benefits may or may not be accurate.* All deductibles and copayments are due at the time of service. You will be billed for services not paid for by your insurance at the contracted rate. Your payment is expected within 10 days upon receipt of a bill from us. _____**initial**

Missed Appointments: If an emergency arises and you cannot make it for a scheduled appointment please call us ahead of time to reschedule. If you have elected to not follow the recommended treatment plan your signature indicates that you agree to discuss this with the doctor so that we may properly close your case. _____**initial**

Massage Appointments: Our massage therapists are independent contractors and we require a minimum of 24 hours notification so our massage therapist can make the necessary changes to their schedule and so that slot can be available for another patient**. If you fail to keep your massage appointment or call at least 4 hours ahead of your appointment you will be billed a NO SHOW fee of $35.** In the event you are sick or have an emergency just let us know as soon as possible. _____**initial**

Workman's Compensation and Personal Injury: If you were injured at work, involved in a collision or personal injury please tell us at this time so that we may provide you with the proper paperwork. _____**initial**

Your health is our primary concern. I have read and understand the policies. _____
Print Name

Signature _____ Date _____

Terms of Agreements

Fees
Due at time of Service. For details see fee schedule

About Chiropractic Care
We are primarily an office of chiropractic. It is not the goal or intention of this office to diagnose, treat or advise about a medical condition. Health comes from within the body; no one can heal you, only you can take the actions which will best serve your optimum health. Chiropractic assists you in that by removing interference to the nervous system. Healing is a process and takes time. Our job is to recommend and deliver the best care to meet your needs based on our examinations and assessments so that you may recover quickly to achieve optimal results. We ask that you be on time to your appointments, and comply with your recommended care plan and schedule. Part of your care may include re-examinations approximately every 8 weeks or more.

The objective of chiropractic is to check the communication between your nervous system and your spine (your backbones, brain, and spinal cord) for interference of the nervous system. We call this interference a subluxation. Interference in the body's communication system can be caused by a lifetime of physical trauma, toxins and stress. A subluxation interferes with health and result is dis-ease. A specific adjustment to correct the subluxation is done allowing the body to function optimally and restore health and vitality.

Chiropractic, physical therapy, massage, acupuncture or therapeutic supplements may be recommended to assist in this healing process. I understand and have read the Agreements above _____
Print Name

Signature _____ **Date** _____

If a ***minor child*** (under 18 years old) I am the legal guardian and agree and understand the preceding information. My signature grants permission for my child to receive chiropractic care. _____
Print Childs Name

Signature _____ Date _____

For office use only (Last revised 4-1-19)
__ Pages signed, dated & in order; DATA BASE: __ Name __ email __ phone # & address __ N'letter
__ Verified ins _____ Rwd insur. w pt __ Welcome Card __ Thank You __ ins card(s) __ info page