

GOALS FOR MY CARE

People see Chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care** - Symptomatic relief of pain or discomfort
- Corrective Care** - Correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive Care** - Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition

Patient's Signature

Date

MEDICATIONS I NOW TAKE

- | | |
|---|---|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Pain Killers (including Aspirin) | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood Pressure Medicine | _____ |
| <input type="checkbox"/> Insulin | _____ |

HEALTH HABITS

- | | NO | YES |
|----------------------------|----------------|------------------------|
| Do you smoke? | ___ | ___ packs/day |
| Do you drink alcohol? | ___ | ___ drinks/day |
| Do you drink coffee? | ___ | ___ cups/day |
| Do you exercise regularly? | ___ No | ___ Moderate ___ Daily |
| Do you wear | ___ Heel Lifts | ___ Sole Lifts |

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Shingles | For Women |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Kidney Problems | Are you pregnant? ___ Yes ___ No |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Hepatitis | Are you nursing? ___ Yes ___ No |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer | Are you taking birth control? ___ Yes ___ No |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Chemotherapy | Do you experience painful periods? ___ Yes ___ No |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Anemia | Do you have irregular cycles? ___ Yes ___ No |
| <input type="checkbox"/> Numbness of pain in Arms/Legs/Hands | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | Do you have breast implants? ___ Yes ___ No |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Thyroid Problems | |
| | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Digestive Problems | |
| | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Diabetes | |

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature

Date

Guardian or Spouse's Signature Authorizing care

Date

Who should receive bills for payment on your account?

Patient

Spouse

Parent

Worker's Comp

Auto Ins.

Medicare

Medicaid

Personal Health Insurance

Ownership of X-Ray Films.

It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

IN AN EMERGENCY, CONTACT:

Name _____
Relationship _____
Work Phone _____
Home Phone _____
Cell Phone _____

ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Insurance Co. Name _____

Group # (Plan, Local, Policy#) _____

Address _____

Phone _____

ABOUT THE INSURED PERSON

Name _____

Insured's Social Security# _____

Relation _____

Date of Birth _____

Employer _____



Family History

Because “health” and “lack of health” is passed down within one’s family,
Please circle any familial illnesses.

Spouse	<ul style="list-style-type: none"> • Headaches • Migraines • Neck Pain • Low Back Pain • Pain or Numbness of the Hands or Feet 	<ul style="list-style-type: none"> • Arm Pain • Leg Pain • Menstrual Cramps • Scoliosis • Cancer 	<ul style="list-style-type: none"> • Diabetes • Allergies • Asthma • Heart Attack • Heart Disease • Other: _____
Father	<ul style="list-style-type: none"> • Headaches • Migraines • Neck Pain • Low Back Pain • Pain or Numbness of the Hands or Feet 	<ul style="list-style-type: none"> • Arm Pain • Leg Pain • Menstrual Cramps • Scoliosis • Cancer 	<ul style="list-style-type: none"> • Diabetes • Allergies • Asthma • Heart Attack • Heart Disease • Other: _____
Mother	<ul style="list-style-type: none"> • Headaches • Migraines • Neck Pain • Low Back Pain • Pain or Numbness of the Hands or Feet 	<ul style="list-style-type: none"> • Arm Pain • Leg Pain • Menstrual Cramps • Scoliosis • Cancer 	<ul style="list-style-type: none"> • Diabetes • Allergies • Asthma • Heart Attack • Heart Disease • Other: _____
Son	<ul style="list-style-type: none"> • Headaches • Migraines • Neck Pain • Low Back Pain • Pain or Numbness of the Hands or Feet 	<ul style="list-style-type: none"> • Arm Pain • Leg Pain • Menstrual Cramps • Scoliosis • Cancer 	<ul style="list-style-type: none"> • Diabetes • Allergies • Asthma • Heart Attack • Heart Disease • Other: _____
Daughter	<ul style="list-style-type: none"> • Headaches • Migraines • Neck Pain • Low Back Pain • Pain or Numbness of the Hands or Feet 	<ul style="list-style-type: none"> • Arm Pain • Leg Pain • Menstrual Cramps • Scoliosis • Cancer 	<ul style="list-style-type: none"> • Diabetes • Allergies • Asthma • Heart Attack • Heart Disease • Other: _____