

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond to our treatment, we will not accept your case. THANK YOU

NAME _____ AGE _____ BIRTHDAY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

MARITAL STATUS M S D W #CHILDREN _____ OCCUPATION _____

SPOUSE'S NAME _____ HOW DID YOU HEAR ABOUT US? _____

HEALTH INFORMATION

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES NO

WHAT IS YOUR MAJOR COMPLAINT? _____

LIST ANY OTHER HEALTH PROBLEMS (i.e. headaches, allergies, weight problem, digestion, stress)

HOW LONG HAVE YOU HAD YOUR PRIMARY CONDITION? _____ ANY SIMILAR CONDITIONS? YES NO

WHAT AGGREGATES YOUR CONDITION? _____

IS THIS CONDITION: (circle all that apply) GETTING WORSE GETTING BETTER ON AND OFF CONSTANT

IS THIS CONDITION INTERFERING WITH: WORK SLEEP DAILY ROUTINE OTHER

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? _____

OTHER DOCTORS WHO TREAT THIS CONDITION: _____

WHAT HAVE YOU TRIED TO DO TO GET RID OF THIS PROBLEM THAT DID NOT WORK? _____

LIST ALL SURGICAL PROCEDURES _____

LIST ALL CURRENT MEDICATIONS _____

LIST NUTRITIONAL SUPPLEMENTS _____

HAVE YOU BEEN IN AN AUTO ACCIDENT IN: PAST YEAR PAST 5 YEARS OVER 5 YEARS NEVER

DESCRIBE: _____

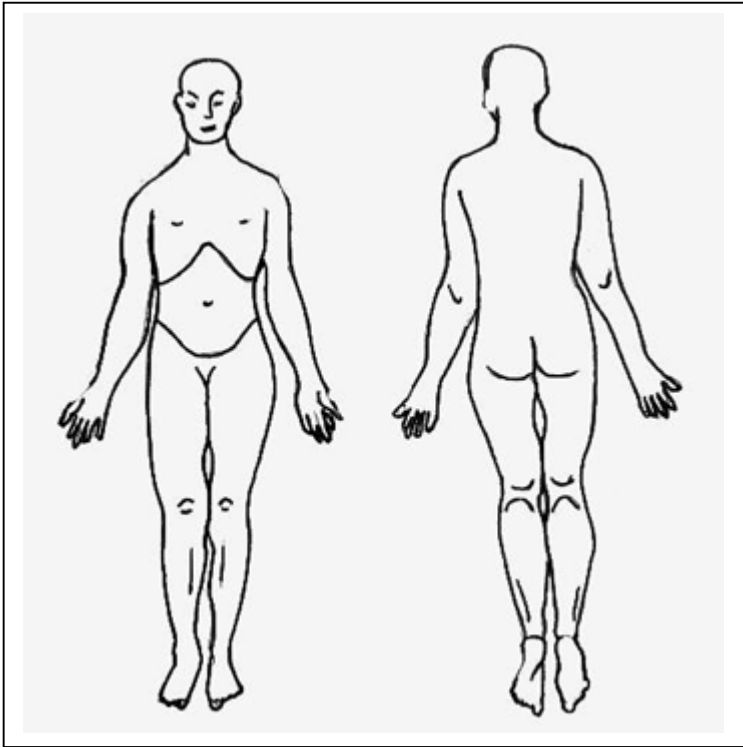
HAVE YOU HAD ANY OTHER INJURY/ACCIDENT? PAST YEAR PAST 5 YEARS OVER 5 YEARS NEVER

DESCRIBE _____

IS THIS CONDITION DUE TO AN AUTO ACCIDENT? Y N

DATE OF LAST PHYSICAL EXAM: _____ NAME OF DOCTOR _____

(TURN OVER)



HAVE YOU EVER SUFFERED FROM:

DIZZINESS		Y
BACKACHES	Y	N
HEART TROUBLE	Y	N
DIABETES	Y	N
ARTHRITIS	Y	N
HEADACHES	Y	N
ASTHMA	Y	N
NEURITIS	Y	N
DIGESTIVE DISORDERS	Y	N
SINUS TROUBLE	Y	N
NECK PAIN	Y	N

PLEASE INDICATE WITH CIRCLES WHERE YOU ARE EXPERIENCING PAIN.

MANY HEALTH PROBLEMS ARE THE RESULT OF HEREDITARY SPINAL WEAKNESS, THUS INFORMATION ABOUT YOUR FAMILY MEMBERS WILL GIVE US A BETTER PICTURE OF YOU TOTAL HEALTH.

FAMILY MEMBER NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE INFORMATION:

DO YOU HAVE HEALTH INSURANCE? Y N

NAME OF INSURANCE COMPANY _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS CHIROPRACTIC OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE CHIROPRECAIT OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIREDTLY 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'S SIGNATURE _____ DATE _____