Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Type of pain: Stiffness Swelling Other Secreation	Name		10.00	Soc.	Sec. #		
State							
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rhom may we thank for referring you? otify in case of emergency							
Home Phone Business Phone Phone Busin	N.						
Primary Insurance First Name	•						
Primary Insurance Primary Insurance							
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Last Name			W				
Last Name		Drin	nary Insura	n <i>co</i>			
Last Name			ilary ilizoia				B
Reason for Visit Active you ever seen a chiropractor? Yes No If yes, when and why?	Person Responsible for Account	Last Name		Fi	rst Name	v	Initial
City Home Phone Email Occupation Susiness Address Business Phone Business Phone Susiness Address Business Phone Susiness Phone Susiness Phone Susiness Phone Susiness Email Occupation Phone Subscriber # Subscriber	Pelation to Patient						
Home Phone Email Coccupation Susiness Address Business Phone Susiness Address Business Phone Susiness Email Contract # Group # Subscriber # Subscri							
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Person Responsible Employed by Occupation Business Address Business Phone Business Address Business Phone Business Email Insurance Company Phone Insurance Email Contract # Group # Subscriber # Name of other dependents under this plan Reason for Visit Have you ever seen a chiropractor? Yes No If yes, when and why? Please describe your pain and its location: When did symptoms begin (date)? Have you had similar conditions in the past? Its pain getting: Worse Better Same Comes and goes How often do you have this pain? If so, when and where? Activities or movements that are difficult/painful to perform: Sitting Walking Bending Lying down Lifting Type of pain: Sharp Dull Throbbing Aching Burning Tingling Numbness Cramp Stiffness Swelling Other It pain interforing with Work Sleep Daily Routine Recreation							
Business Phone Business Phone Business Email Insurance Company Phone Subscriber # Subscriber # Name of other dependents under this plan Reason for Visit Have you ever seen a chiropractor? Yes No If yes, when and why? Your reason for this visit: Please describe your pain and its location: When did symptoms begin (date)? Have you had similar conditions in the past? Is pain getting: Worse Better Same Comes and goes How often do you have this pain? Have you been treated by a medical physician for this condition? If so, when and where? Activities or movements that are difficult/painful to perform: Sitting Walking Bending Lying down Lifting Type of pain: Sharp Dull Throbbing Aching Burning Tingling Numbness Cramp Stiffness Swelling Other Is pain interfacing with: Work Sleen Daily Routine Recreation							
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Please describe your pain and its location: When did symptoms begin (date)? Have you had similar conditions in the past? Is pain getting:	Have you ever seen a chiropractor?	☐ Yes ☐ No If yes, whe	n and why?				
When did symptoms begin (date)? Have you had similar conditions in the past? Is pain getting:	Your reason for this visit:						
Is pain getting:	Please describe your pain and its loca	ition:		2			
Have you been treated by a medical physician for this condition?	When did symptoms begin (date)?	Have you	had similar con	ditions in the	oast?		
If so, when and where?							
Activities or movements that are difficult/painful to perform:	Have you been treated by a medical I	physician for this condition?					
Type of pain: Stiffness Swelling Other Secreation	If so, when and where?						
Stiffness Swelling Other Swelling Daily Routine Recreation Recreation Recreation Swelling Daily Routine Recreation Recreation Swelling Daily Routine Recreation Swelling Daily Routine Recreation Swelling Daily Routine	Activities or movements that are diffi	cult/painful to perform:	☐ Sitting	□ Walking	☐ Bending	□ Lying down	☐ Lifting
☐ Stiffness ☐ Swelling ☐ Other			☐ Aching	☐ Burning	☐ Tingling	□ Numbness	☐ Crampin
Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation	y the property of the second	☐ Swelling ☐ Other			N ()	208	
	Is pain interfering with: Work	I Sleep □ Daily Routine	☐ Recreation				

Please complete both sides. .

Observation and Easting Control		h History			
(including the last any medication (including	ing pain killers) you are taking:				
Please list any serious injuries you	ı have had in the last 10 years:				
Description					Date
Falls	EMPERIOR TO THE TOTAL THE				
Head Injuries					***
Broken Bones					
Dislocations					
Surgeries					
Other Serious Injuries					
Women: Are you pregnant? ☐ Y	□ N If so, how far along?		Nursing 🗆 Y		
	Medical	Conditio	ons		
Check (🗸) yes or no whether you	ı have had or currently have any of th	ne following	medical conditions?		
☐ Y ☐ N Heart Attack/Stroke	☐ Y ☐ N Arthritis	0 7 0 1	N Ringing in Ears	\square Y \square N	Ulcer/Colitis
☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Frequent Neck Pain		N Severe/	\square Y \square N	Gout
☐ Y ☐ N Alcohol/Drug Abuse	☐ Y ☐ N Jaw Pain		Frequent Headaches		Numbness, where?
☐ Y ☐ N Fainting/	☐ Y ☐ N Wrist Pain		N Diabetes/Tuberculosis		
Seizures/Epilepsy	☐ Y ☐ N Shoulder Pain		N Dizziness	\square Y \square N	Tingling, where?
☐ Y ☐ N Shingles	☐ Y ☐ N Arm Pain		N Emphysema/Glaucoma		
☐ Y ☐ N Psychiatric Problems	☐ Y ☐ N Leg Pain		N Kidney Problems		Muscle Spasms,
☐ Y ☐ N Difficulty Breathing	☐ Y ☐ N Lower Back Problems		N Artificial Bones/Joints	where?	
☐ Y ☐ N Hepatitis	☐ Y ☐ N Severe/		N Cancer		
□Y□N Anemia	Frequent Earaches		N HIV Positive/AIDS		
	Perso	nal Habit			
	Heavy M	loderate	Light	None	
Alcohol					
Coffee					
Tobacco	_				
Drugs					
Exercise Sleep					
Appetite					
	A	norization			
Lhave reviewed the information	on this questionnaire and it is accur		est of my knowledge Tunde	erstand tha	at this information will be
used by the chiropractor to help inform the chiropractor.	o determine appropriate and healthfu	al chiropract	ic treatment. If there is any	change in	my medical status, I wil
I authorize my insurance comparendered. I authorize the use of	any to pay to the chiropractor or chi this signature on all insurance submi	ropractic grossions.	oup all insurance benefits o	therwise p	payable to me for service
I authorize the chiropractor to re for all charges whether or not pa	elease all information necessary to se aid by insurance.	cure the pay	yment of benefits. I understa	and that I	am financially responsibl
Signature			Date	.	8

Payment is due in full at time of treatment, unless prior arrangements have been approved.