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Step One: About You

Full Name _____ Male Female
 What do you prefer to be called? _____ Date _____
 Age _____ Date of Birth _____ SS# _____
 Home Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Mobile Phone _____
 eMail Address _____
 Referred By _____
 Employer Name _____ How Long? _____
 Occupation _____ Work Phone _____
 Employer Address _____
 City _____ State _____ Zip _____
 Marital Status: Single Married Divorced Separated Widowed
 Spouses Name _____

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Step Two: Insurance Information

Insurance Carrier Name _____
 Phone Number _____
 Insured's Name _____
 Insured ID# _____
 Date of Birth _____

Please present your insurance ID card(s) to the front desk Chiropractic Assistant

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Step Three: Reason for Visit

Have you ever been treated by a Chiropractor in the past? Yes No
 If yes, please explain: _____
 The reason for this visit is a result of: Work Sports Auto Trauma Chronic
 Please explain _____

 Describe the pain and it's location _____

 Date this condition began _____
 Is the condition getting worse? Yes No Constant Comes & Goes
 Is the condition interfering with your: Work Sleep Daily Routine
 If so, please explain: _____
 Have you had this or similar conditions in the past? Yes No
 If so, please explain: _____
 Has a Medical Physician for this condition treated you? Yes No
 If so, please explain: _____

4 Step Four: In Case of Emergency

Who should we contact? _____ Relation to you _____
Home Phone _____ Work Phone _____

5 Step Five: Health History

Are you taking any of the following medications (check all that apply):

Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Please list below any other serious medical condition(s) you have or ever had:

Please list below anything that you may be allergic to:

List below previous surgery/adjustments with dates:

List below any past serious accidents with dates:

Do you smoke: Yes No If yes, how much? _____ How Long? _____

Are you currently wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

What is the age of your mattress? _____ Is it comfortable: Yes No

For Women. Are you taking birth control: Yes No

Are you pregnant: Yes No If yes, how long? _____ Nursing: Yes No

6 Step Six: Account Information

Person ultimately responsible for account. *Check this box if same as Step One or Step Two:*

Full Name _____ Relation to you _____

Billing Address _____ Work Phone _____

City _____ State _____ Zip _____

SS# _____ D.L.# _____

Payment Method Cash Check Credit Card

Credit Card Type: _____ Card #: _____

Authorized Signature: _____ Expiration Date: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and member.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the doctor. If account balance is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and care. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.