

PERSONAL HISTORY

Date _____

Please complete this form to the best of your ability. If you need help our receptionist will be glad to assist you!

Full Name _____ Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Cell _____

E-mail _____ Sex: M F Single / Separated / Married / Widowed / Divorced

Birth _____ Social Security# _____ How did you hear about our office _____

Employed / Student / Other _____ Emergency Contact _____ Phone _____

Spouse's Name _____ Date Of Birth _____ Social Security# _____

Accident Injury and Insurance Information

Could your present problems be due to an accident-injury? _____ Date _____

Type of accident-injury (circle): **Auto, On-the-Job, Slip/Fall, Personal, Other** We do not accept assignment on work related injuries.

Name of Attorney handling your case _____ Phone _____

Type of Insurance you plan to use to help pay your account (circle): **Auto Health Medicare Self-Pay Other**

Insurance company _____ Phone _____

Insured's Name _____ Insured's DOB _____

Your Injury, Illness, or Condition

What is your injury, illness or condition _____

Do you suffer from any condition other than that which you are now consulting us? _____

Have you had previous Chiropractic care? YES NO Condition treated _____ Month/Year of last visit _____

Health Problems

CIRCLE conditions you have NOW and UNDERLINE conditions you have had PREVIOUSLY:

Low Back Pain	Fractured Bones	Spinal Taps	Fainting
Arm Pain	Dislocation	Scoliosis	Birth Defects
Headaches	Joint Replacement	Diabetes	Osteoporosis
Neck Pain	Metal Screws/implants	High Blood Pressure	Cancer
Pain Between Shoulders	Cervical Whiplash	Stroke	Tumor
Leg Pain	Electronic Implant	Aneurysm	Cyst
Cold/Tingling Fingers or Toes	Pacemaker	Convulsions	Ear Infections
Numbness	Ruptured Spinal Disc	Seizures	Birth Complications
Allergies	Slipped spinal disc	Memory Lapse	Asthma
Loss of Sleep	Pinched Nerve	Dizziness	Bed Wetting
Stomach/Digestive Problems	Spinal Surgery	Concussion	Heart Disease
Walking problems	Spinal Infections	Knocked Unconscious	Fever

Are you Pregnant? Y _____ N _____ Other serious illness _____

Treatment Authorization

Today you'll receive a free initial consultation with the doctor. If further tests are needed such as exams or x-rays, the necessity and cost will be explained before they are performed. You'll be happy to know that these tests are covered by most insurances. I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate. I grant authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's signature (x) _____

Date _____

Entered by _____

Name _____

Patient # _____

If your injuries could be due to an AUTO ACCIDENT, please fill out this page.

NOTE: It is our policy to except assignment of personal injury (auto) claims when your auto insurance has medical payments coverage. This allows you to get care from our office without making payment when services are rendered. Your insurance company will then bill the responsible parties. If you do not have automobile medical payments coverage then you must obtain legal representation by an attorney for us to accept assignment. If your injuries are due to an accident we bill your auto insurance first (primary), if there is a coverage limitation we will then bill any other insurance (auto liability, major medical, etc.)

Accident Patient History

Date of Accident _____ Time _____

Were you: Driver Passenger Front Seat Back Seat

Were you wearing a Seat Belt? Y____ N____ Shoulder Harness? Y____ N____

Description of Accident

Were you struck: From Behind In Front Right Front Right Middle Right Rear
 Left Front Left Middle Left Rear

Were you: Moving Stopped Turning Right Turning Left

Approximate speed of automobiles at time of impact _____

Did you see the accident coming? Y____ N____

Upon impact which way was your body thrown? Forward Backward Right Left

Did you hit your head on anything? Y____ N____ What? _____

Lose consciousness? Y____ N____ How Long? _____

Amount of damage to vehicle? _____

Type of vehicle? _____

When did the pain begin? _____

Since Motor vehicle accident- pain is: Less Same Worse

Transported to hospital? Y____ N____ Hospital Name: _____

X-rays taken? Y____ N____

Instructions from ER Doctor _____

Have you seen another Dr. since Motor Vehicle Accident? Y____ N____

Dr. Name _____

What treatment did you receive? _____
