WELCOME

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT.

Name_____ **Date**_____

PATIENT INFORMATION

Last Name_____

First _____ M.I. _____

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Date of Birth _____ Age _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name _____

No. of Children _____

School/Employer _____

Occupation _____Years on Job _____

SS# _____

How did you hear about our office?
☐ Radio ☐ TV ☐ Website ☐ Other_____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____Work/Cell _____

Email Address _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Home _____Work/Cell _____

Relationship _____

ACCIDENT INFORMATION

Is your condition due to an accident? ☐ Yes ☐ No

Date of accident _____

Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other

To who have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

Attorney Name (if applicable) _____

INSURANCE INFORMATION*

Insured's Name_____ Insured's DOB _____ Sex ☐ M ☐ F

Insured's Address_____ City _____ State _____ Zip _____

Insured's Phone_____ Insured's Employer_____

Insurance Co. _____ Plan/Program Name_____

Insured's ID # _____ Insured's Group #_____

Patient's Relationship to Insured_____

Do you have Medicare? Y /N

*Please present your insurance card(s) to the receptionist.

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care for any reason, any fee for professional services rendered me will be immediately due and payable.

Patient/Guardian Signature _____ Date _____

Note: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. Thank You.

PAST HEALTH HISTORY

How would you rate your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Have you gained or lost any weight in the last year? Y / N Amount _____ Reason _____

Have you ever been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: _____

List Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Transfusions		

Have you ever:	YES	NO	Describe Briefly
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been hospitalized for anything other than surgery?	☐	☐	
Have you ever had any mental/emotional disorders?	☐	☐	When?
Have others in your family had such disorders?	☐	☐	When?

Date of Last:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal Exam	☐	☐	☐	☐
Physical Exam	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
Urine Test	☐	☐	☐	☐

Please check the following conditions that you have had:

☐ Alcoholism	☐ Chorea	☐ Fever blisters	☐ Miscarriage	☐ Scarlet Fever
☐ Anemia	☐ Cold Sores	☐ Goiter	☐ Multiple Sclerosis	☐ Stroke
☐ Appendicitis	☐ Diabetes	☐ Gout	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Diphtheria	☐ Heart Disease	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Emphysema	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chicken pox	☐ Epilepsy	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Walking
☐ Lifting
☐ Twisting
☐ Light labor
☐ Heavy labor
☐ Other _____
_____
_____

HABITS

☐ Smoking	Packs/Day _____	☐ Exercise	Excellent/Good/Fair/Poor
☐ Alcohol	Drinks/Week _____	☐ Sleep	Excellent/Good/Fair/Poor
☐ Coffee/Caffeine	Cups/Day _____	☐ Diet	Excellent/Good/Fair/Poor
☐ High Stress Level	Reason _____	☐ Drugs	Heavy/Mod/Light/None

Have you ever worked or lived somewhere where you were exposed to toxic metals, gases, fumes, dusts, radioactive material or chemicals? Y / N

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable

Do you primarily sleep on your ☐ back ☐ side ☐ stomach ?

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ?

MEDICATIONS (include OTC, Rx and recreational)

_____
_____
_____
_____

Do you have an allergy to any drug? _____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____