ChiropracticWorks
A Healthy Body for a Healthy Life

Confidential Patient Information

Date ____________

Personal Information

First Name: ____________ Last Name: ____________ Middle Initial: ________

Address: ____________

City / State / Zip ____________

Home Phone: (   )____________ Work Phone: (   )____________

Mobile Phone: (   )____________ E-mail: ____________

Social Security #:____________ Birth Date:____________ Age:________ Sex: ○ M ○ F

Occupation: ____________Employer's Name: ____________

Work Address: ____________

City / State / Zip: ____________

Marital Status: ○ S ○ M ○ D ○ W Spouse's Name:____________ # of Children: ________

How were you referred ____________

Name of Primary Physician: ____________

Emergency Contact

Name:____________ Relation: ____________

Home Phone: (   )____________ Work Phone: (   )____________

Address: ____________

____

Insurance Information

Insurance Company: ____________

Phone #____________ Address: ____________

Insured's Name____________ Insured's SS#____________ Group # ____________

Insured's Birth Date:____________ Insured's Employer: ____________

Health Information

What is your reason for consulting our office? ____________

____

When did this health concern(s) begin?____________

If this is an injury, describe what happened?____________

Have you experienced this health concern(s) before? ○ Yes ○ No When? ____________

What aggravates this condition? ____________

What decreases the condition / pain? ____________

Have you seen another doctor for this condition? ○ Yes ○ No

Doctor's Name: ____________ Date consulted:________

Does this condition interfere with your sleep? ○ Yes ○ No

In what position do you sleep? ❍ Back ❍ Side ❍ Stomach

Do you sleep with a pillow? ❍ Yes ❍ No How many?________________

How long have you been living this way? ______ Weeks ______ Months ______ Years

What results do you want? ❍ Maintain health ❍ Restore Health ❍ Reduce Pain

Do you wear a heel lift? ❍ Yes ❍ No If so, which side? ❍ Right ❍ Left

Please Check The Activities Below During Which You Experience Difficulty

❍ Lying on back	❍ Getting in/out of car	❍ Pulling	❍ Sitting	❍ Standing for long periods
❍ Lying on side	❍ Dressing Self	❍ Reaching	❍ Bending forward	❍ Sneezing
❍ Turning over in bed	❍ Sexual Activity	❍ Kneeling	❍ Bending backward	❍ Coughing
❍ Lying flat on stomach	❍ Pushing	❍ Stooping	❍ Walking	❍ Other: ________

If female, are you pregnant? ❍ Yes ❍ No ❍ Not sure If yes, what is your due date:________________

List all medications you are taking now, including over the counter medication.________________

____

Have you ever had any surgeries or hospitalizations? ❍ Yes ❍ No Please List:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:

Have you been x-rayed in the last 12 months? ❍ Yes ❍ No When?:________________

Have you ever been seen by a chiropractor before? ❍ Yes ❍ No Please List:

Name of chiropractor:	Dates:	Name of chiropractor:	Dates:

Please Check All Health Challenges: Past and Present

❍ Loss of concentration	❍ Neck stiffness	❍ Shortness of breath	❍ Cold hands	❍ Anemia
❍ Eyes sensitive to light	❍ Neck motion restricted	❍ Irritable	❍ Cold feet	❍ Heart disease
❍ Memory loss	❍ Upper back pain/stiffness	❍ Anxiety	❍ Jaw pain	❍ Arthritis
❍ Heavy feeling of head	❍ Mid back pain/stiffness	❍ Depression	❍ Hypertension	❍ HIV (Aids)
❍ Dizziness	❍ Right/Left shoulder pain	❍ Insomnia	❍ Diabetes	❍ Cancer
❍ Ringing in ears	❍ Right/Left arm pain	❍ Fatigue	❍ Convulsions	❍ Other
❍ Loss of balance	❍ Pins & needles arms/legs	❍ Excess Perspiration	❍ Allergies (please list)	________
❍ Loss of smell	❍ Right/Left leg pain	❍ Digestive trouble	________	________
❍ Loss of taste	❍ Vision problems	❍ Nausea	________	________
❍ Pain behind eyes	❍ Sinus trouble	❍ Vomiting	________	________
❍ Fainting	❍ Nervousness	❍ Diarrhea	________	________
❍ Palpitation	❍ Chest pain	❍ Constipation	________	________

Please List Any Previous Trauma : Major and Minor

Please list any automobile accidents you have had (even if you think they are minor): ______________________

____

____

Please list any falls you have had (slips on ice, down stairs, falls as a child, etc): ______________________

____

____

Please list any work related accidents you have had (even if you think they are minor): ______________________

____

____

Authorization and Assignment

I authorize ChiropracticWorks to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize direct payment to you of any sum I now or hereafter owe you by my attorney out of the preceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or part upon the charges made for the services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint ChiropracticWorks the authority necessary to endorse and cash any checks, drafts or money orders which are make payable to the undersigned or as co-payee with this office when said payments are due to services rendered on behalf of the undersigned by the office.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and after that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Signature______________________ Date______________________