

"The Part can never be well unless the Whole is well." PLATO

(Please Print)

Date: _____ / _____ / _____

Patient No. _____

Name _____ Social Security Number _____ - _____ - _____

Street Address _____ Mailing Address _____

City _____ State _____ Zip: _____ DOB _____ / _____ / _____ Age _____

Male/ Female _____ Marital Status: (Single / Separated / Married / Widowed / Divorced) _____ No. of Children _____
(Please Circle) (Please Circle)

Phone _____ Wk _____ Cell _____

Email _____

Occupation _____ Employed By _____

Name of Spouse or Parent (if minor) _____

Spouse/Parent Employer _____ Wk Phone _____

Address (if different) _____

Birth Date: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

Phone _____ Wk _____ Cell _____

Is this visit due to an accident? home _____ work _____ auto _____

AFLAC: Yes / No Policy # _____

Insurance _____ Policy No. _____

Please check the type of care desired:

___ Temporary Relief ___ Control of Immediate Problem ___ Total Health Care

___ I prefer the doctor select the type of care best for me.

Have you had chiropractic care before? Y N Dr. _____ When? _____

Whom may we thank for referring you to our office? _____

Health Related Goals:

Are you interested in:

- Weight loss/nutritional program _____
- Supplement support _____
- Decompression therapy _____

~~~~~  
(Please Complete Other Side)

**CONFIDENTIAL**

**Check The Body Signals You Are Currently Experiencing:**

|                            |                   |                            |
|----------------------------|-------------------|----------------------------|
| ___ Tension                | ___ Hip Pain      | ___ Headache               |
| ___ Pain Between Shoulders | ___ Back Pain     | ___ Shortness of Breath    |
| ___ Numbness in Toes       | ___ Fatigue       | ___ Sleeping Problems      |
| ___ Neck Pain              | ___ Shoulder Pain | ___ Pins & Needles in Arms |
| ___ Numbness in Fingers    | ___ Chest Pain    | ___ Other_____             |

Previous major injuries (auto, falls, etc.)? \_\_\_\_\_

Previous Surgery? \_\_\_\_\_

Medications (presently or recently taken)? \_\_\_\_\_

**I have read and understand the HIPAA Notice of Privacy Policies. I do have the right to request a copy of these policies.**

**I understand and agree that health and accident insurance policies are an arrangement *between an insurance carrier and myself*. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.**

***However, I clearly understand and agree that all services rendered 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 and treatment, any fees for professional services rendered me will be immediately due and payable.**

**I hereby authorize the Doctor to examine and treat any condition as he/she deems appropriate through use of Chiropractic Health Care and I give authority for these procedures to be performed.**

(if applicable) **PREGNANCY WARNING:** I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I authorize the Doctor and whomever she designates as her assistant to take the X-rays.

**X**\_\_\_\_\_ **Date:**\_\_\_\_\_