

WELCOME!

Today's Date _____

Name _____ Date of Birth _____ Phone _____

What do you prefer to be called? _____ Age _____ SS# _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer Name _____

Work Phone # _____ Cell# _____ Employer's Address _____

Marital Status: ()Single ()Married ()Divorced Spouse's Name _____

of children and ages _____

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

Have you ever been treated by a Chiropractor before? ()Yes ()No If so Whom? _____

INSURANCE INFORMATION

Insured's Name _____ Relation _____ Date of Birth _____

Insured's SS# _____ Insured's Employer _____

Your Ins. Co. _____ Group # _____

Ins Co. Address _____

Ins Co. Phone # _____

Person Ultimately Responsible for Account (Name and Address if different from above) _____

REASON FOR VISIT

The reason for this visit is a result of (Please Circle): Work Sports Auto Trauma Chronic

Explain what Happened: _____

Drs. Notes _____

Please describe the pain and its location: _____

Drs. Notes _____

When did the condition begin? ___ / ___ / ___

On a scale of 0-10 please rate your pain (0=no pain, 10=extreme pain) _____

Is this condition getting worse? ()Yes ()No ()Constant ()Comes and Goes

Is this condition interfering with your (Please Circle): Work Sleep Daily Routine?

If so, please explain _____

Do you have a prior history of similar complaints? _____ If yes, dates, prior treatment, results, etc. _____

Drs. Notes _____

Have you ever been treated by a Medical Physician for this condition? ()Yes ()No

If so, where? _____

For what condition? _____

Please describe any additional complaints: _____

PAST MEDICAL HISTORY

Have you ever had any of the following diseases/medical conditions?

Heart Attack/Stroke

Heart Surgery/Pacemaker

Heart Murmur

Congenital Heart Defect

Mitral Valve Prolapse

Artificial Valves

Alcohol/Drug Abuse

Venereal Disease

Hepatitis

HIV+/ Aids

Shingles

Cancer

Frequent Neck Pain

Emphysema/Glaucoma

Anemia

High/Low Blood Pressure

Psychiatric Problems

Rheumatic Fever

Severe/Frequent Headaches

Kidney Problems

Ulcers/Colitis

Fainting/Seizures/Epilepsy

Sinus Problems

Asthma

Diabetes/Tuberculosis

Difficulty Breathing

Chemotherapy

Lower Back Problems

Hypothyroid

Hyperthyroid

Artificial Bones/Joints

Arthritis

Please List any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to _____

List previous surgeries/treatment with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

For Women: Are you Pregnant? ()Yes ()No Nursing? ()Yes ()No

Date of Last Menses: ___/___/___

Are you taking any of the following medications?

Pain Killers Muscle Relaxants Blood Thinners Tranquilizers Insulin Birth Control Pill

Please list any medications you are currently on and what they for.

Are you taking any vitamins or supplements? Yes ()No ()

If so, please list: _____

HABITS & ACTIVITY

Do you or have you ever smoked? ()yes ()No Packs per day: _____

Do you or have you ever used alcohol? ()Yes ()No Amount/Type _____

Do you drink caffeinated beverages? ()Yes ()No How much and type: _____

Regular Exercise? ()Yes ()No Activity and intensity: _____

Do you feel you eat a well balanced diet? ()Yes ()No

Are you interested in a complete nutritional profile to assess your specific nutritional needs? ()Yes ()No

Are there any particular activities of daily living that you are having difficulty with due to your presenting complaint(s)?

Are there any other health concerns that we did not yet ask about that we should know about? () Yes () No

Is It ok to leave a detailed message on your answering machine? () Yes () No

Drs. Notes: _____

IN THE EVENT OF EMERGENCY

Who should we contact? _____ Relation _____

Home Phone# _____ Work Phone# _____

Who is your Medical Doctor? _____ Phone # _____

- 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 patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, 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.
- I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature _____ Date _____

- If patient is a minor, I agree to the above statements and authorize the doctors of Front Street Chiropractic to diagnose and treat this patient.

X _____ Date _____
Signature parent/guardian

