

Welcome Form

1

Name: _____

What You Prefer to Be Called: _____

Male Female Birth Date: ___/___/___ Age: ___ SS#: ___-___-___

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Please circle the phone number(s) that is(are) the best to contact you:

Home: () _____ Work: () _____ Other: () _____

Email Address: _____

Employer: _____ Occupation: _____

Marital Status: married single divorced widowed

Spouse's Name: _____ Occupation: _____

Children's Names and Ages: _____

If Minor: Mother's Name: _____ Father's Name: _____

Family Doctor's Name: _____ Phone: () _____

Family Doctor's Address: _____

Referred By: _____

2

PAYMENT INFORMATION:

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the insurance coverage.

Insured's Name: _____ Insured's Birth Date: _____

Insurance Company: _____ Insured's ID: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

3

Current Condition

Have you had previous chiropractic care? _____

Reason for visit _____

When did your symptoms appear? _____

How did this condition develop? (fall, accident, gradual, sudden, etc) _____

Is your condition getting worse over time? _____ Have you had the same/similar problems before? _____

Have you seen other doctors for this complaint? _____ Name: _____

What percent of awake hours does it affect you? less than 25% ___ 25% ___ 50% ___ 75% ___ 100% ___

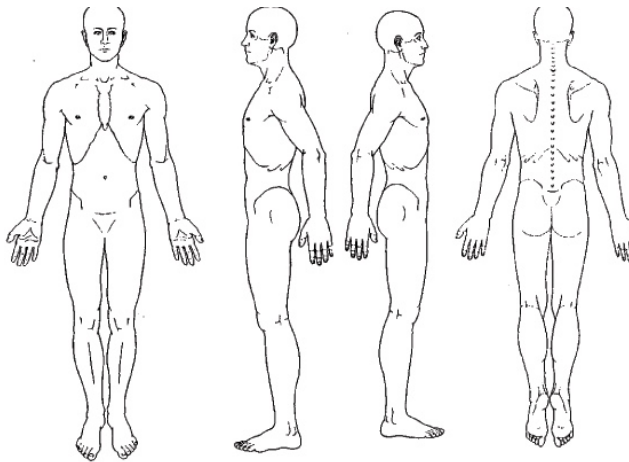
Does it interfere with your: () work () sleep () daily routines () recreation () other _____

Activities which are painful: () standing () sitting () lying down () walking () bending
 () other _____

Type of pain: () sharp () dull () throbbing () numbness () aching () shooting () burning
 () tingling () cramps () stiffness () swelling

Pain Location

Please circle or mark with an X, the areas of complaint on the diagram below.



4

Health History

Please mark with an X to indicate if you have any of the following diseases/medical conditions.

If condition happened in the past, please indicate by marking with a "P".

- | | | |
|-----------------------------|------------------------------|-------------------------------|
| AIDS/HIV () | Gall Stones () | Neck Pain () |
| Alcoholism () | Glaucoma () | Osteoporosis () |
| Allergy Shots () | Goiter () | Pacemaker () |
| Ankle/Foot Pain () | Gout () | Parkinsons () |
| Anemia () | Headaches (frequent) () | Pelvic Pain () |
| Anorexia () | Heart Attack () | Polio () |
| Appendicitis () | Heart Disease () | Prostate problems () |
| Arthritis () | Heart Murmur () | Psychiatric Care/Problems () |
| Artificial Bones/Joints () | Hepatitis () | Rheumatic Fever () |
| Asthma () | Hernia () | Sciatica () |
| Bleeding disorders () | Herniated Disc () | Scoliosis () |
| Breast Lump () | High Cholesterol () | Seizures () |
| Bronchitis () | High/Low Blood Pressure () | Shingles () |
| Bulimia () | Hip/Leg Problems () | Shoulder/Arm Problem () |
| Cancer () | Irritable Bowel Syndrome () | Sinus Problems () |
| Cataracts () | Jaw Problems () | Stomach Problems () |
| Chemical dependency () | Kidney disease/problems () | Stroke () |
| Congenital Heart Defect () | Knee Pain () | STD () |
| Diabetes () | Liver disease/problems () | Suicide attempts () |
| Difficulty Breathing () | Lower Back Pain () | Thyroid problem () |
| Diverticulosis () | Menstrual Problems () | Tonsillitis () |
| Dizziness () | Mid Back/Rib Pain () | Tuberculosis () |
| Ear Problems () | Migraines () | Tumors () |
| Emphysema () | Miscarriage () | Ulcers () |
| Epilepsy () | Mitral Valve Prolapse () | Whiplash () |
| Fractures () | Multiple Sclerosis () | Wrist/Elbow/Hand Pain () |

Please list any other medical condition(s) you have: _____

Please list ALL medications that you are taking (prescription and non-prescription): _____

Are you under the care of any other healthcare provider or doctor? Yes No

If yes, please provide name(s) and type(s) of doctor: _____

Please list anything that you may be allergic to: _____

Please list all previous surgeries/treatments with dates: _____

Please list any and all accidents with dates (car accidents, falls, broken bones, concussions, etc.):

How would you rate your diet? () Excellent () Good () Fair () Poor

Do you exercise regularly? Yes No If yes, How much? _____ times/week How long? _____

Are you wearing: Heel lifts Sole lifts Custom orthotics Arch supports

What is the age of your mattress? _____ **Is it comfortable?** Yes No

Work Habits: () sitting () standing () repetitive bending () light labor () heavy labor

Other Habits: () smoking - quantity _____ () drinking - quantity _____

() coffee/caffeine - quantity _____ () stress - reason _____

For Women: Are you taking birth control? Yes No

Are you pregnant? Yes No If yes, how long? _____ Are you nursing? Yes N

- ❖ 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 service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider 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.

Signature _____ Date ____/____/____