Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you Can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Confidential Patient Information

Date _____ Soc. Sec. # _____

Name _____ Home Phone _____
Street _____ City _____ Zip _____
Age _____ Birthdate _____ Marital Status: S M W D
Occupation _____ Employer _____
Address _____ Office Phone _____
Spouse/Other Responsible Party_____ Occupation _____
Employer _____ D.O.B. _____
Other nearest Relative _____ Phone _____
Heard about our office through _____
Email _____

Group Health

(fill out if no insurance cards are available)

Primary Ins. Co. _____ Deductible $ _____
Already Paid: ___ Yes ___ No ___ Not Known % Insurance Co. Pays (if known) _____
Insured _____ Ins. I.D.# _____ SSN _____

Other Ins. Co. _____ Deductible $ _____
Already Paid: ___Yes ___ No ___ Not Known % Insurance Co. pays (if known) ____ %
Insured _____ Ins. I.D. # _____ SSN _____

Reason for Visit

Your reason for visit: _____
Please describe your current pain and its location: _____
When did symptoms begin (date)? ____ Have you had similar conditions in the past? ___
If so, when and where? _____
Activities or movements that are difficult/painful to perform:
___ Sitting ___ Walking ___ Bending ___ Lying down ___ Lifting ___ Standing
Type of pain:
___Sharp ___Dull ___ Throbbing ___ Aching ___ Burning ___ Tingling
___ Numbness ___ Cramping ___ Stiffness ___ Swelling ___ Other _____
Is pain interfering with?
___ Work ___ Sleep ___ Daily Routine ___ Recreation
Have you ever seen a chiropractor? ___ Yes ___ No
If yes, when and why? _____

Health History

Please list any medication (including painkillers) you are taking: _____
_____

	Description	Date
Fall	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other Serious Injuries	_____	_____

Women: Are you pregnant? ___ Yes ___ No ___ Not sure. If so, how far along? _____
Nursing? ___ Yes ___ No

Medical Conditions

__Heart Attack/Stroke	__Arthritis	__Ringing in Ears	__Ulcer/Colitis
__Congenital Heart Defect	__Frequent Neck Pain	__Severe/Frequent Headaches	
__Alcohol/Drug Abuse	__Jaw Pain	__Diabetes/Tuberculosis	
__Fainting/Seizures/Epilepsy	__Wrist Pain	__Dizziness	__Gout
__Shingles	__Shoulder Pain	__Emphysema/Glaucoma	
__Psychiatric Problems	__Arm Pain	__Kidney Problems	
__Difficulty Breathing	__Leg Pain	__Artificial Bones/Joints	
__Hepatitis	__Cancer	__Lower Back Problems	
__Anemia	__HIV Positive/AIDS	__Severe/Frequent Earaches	

__Numbness, where? _____
__Tingling, where? _____
__Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	___	___	___	___
Coffee	___	___	___	___
Tobacco	___	___	___	___
Drugs	___	___	___	___
Exercise	___	___	___	___
Sleep	___	___	___	___
Appetite	___	___	___	___

Financial Responsibility Statement

I clearly understand and agree that all services rendered to me are charged directly to me and are my responsibility for payment. I also understand that Discover Chiropractic will submit my insurance as a courtesy to me. In the event of default in payment the undersigned agrees to pay all costs of collection of delinquent amounts, including court cost, and reasonable attorney fees.

Patient's Signature _____ Date _____
Other Responsible Party _____ Date _____