IDEAL CHIROPRACTIC HEALTH CENTER

WELCOME

PERSONAL INFORMATION

Patient Name: ___________________________ Preferred Name: ___________________________

Birthdate: _____/ _____ /_____Age: ___________ □ Male □ Female Weight: _______lbs. Height: _____Ft. _____In.

Mailing Address: ___________________________City: ________________________State: ___________Zip:_______________

Primary Contact Number:______________________________Email:______________________________________

Referred By: ____

Employer: ____Occupation: ____________________________

Text or Email Reminders

Cell Number:_________________Cell Phone Provider:____________________Email address:____________________________

Send Message/email: ______1 day before ______4 Hours before ______1 hour before______45 mins before ______30 mins before

ACCOUNT INFORMATION (Person Ultimately Responsible For Account Parent or Legal Guardian)

Name: ______________________________________Relation: ______________________Work Phone: _________________________

Billing Address:________________________________City:__________________________State: _________Zip:____________________

Payment Method: □ Cash □ Check □ Credit Card

Credit Card Number: ________________________________ Exp. Date: ______________ Initial Here: _____________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office.)

INSURANCE INFORMATION **Please inform front desk of second insurance source.*

Company Name: ___________________________________Phone #:____

Insured's Id #: ______________________________________ Group # (Plan, Local, Policy #): ____________________________________

Insured's Name: ____________________________________ Relation: ____

REASON FOR VISIT

What is your primary pain/complaint? ____

____

Describe the quality of your primary pain/compliant, is it (circle any that apply): sharp, dull, crushing, burning, tearing, or tingling?

*Is there any pattern to the quality of your pain, such as (circle all that apply): intermittent, constant, or throbbing?

*On a scale of 0-10, with 10 being the greatest pain, what is your pain rating when you are suffering (circle a number):0 1 2 3 4 5 6 7 8 9 10?

What date did you first notice your primary pain/complaint? ____

____

Did something cause your primary pain/complaint to begin? ____

____

If you saw any doctor or health care practitioner for your primary pain/compliant, please list their names and what they did, or prescribed, for you:

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Doctor/Health Practitioner's Name:	What they did, or prescribed, for you:

Are you married (Circle an answer): Yes No? If yes, please list your spouse's name.
____

Do you have any children (Circle an answer): Yes No? If yes, please list their name(s) and age(s)?

Name:	Age:

HEALTH HISTORY

Are you taking any of the following medications?

- □ Nerve Pills
- □ Pain Killers (Including Aspirin)
- □ Muscle Relaxers
- □ Stimulants
- □ Blood Thinners
- □ Insulin
- □ Other (s)

Do you have or ever had any of the following conditions? (Please check all that apply.)

□ Heart Attack	□ 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
□ Artificial Bones/Joints	□ Arthritis	□ Constipation	□ Diarrhea

Please list any other serious medical conditions you have or ever had: ______________________________
____

Do you take supplements/vitamins? □ Yes □ No Exercise? □ Yes □ No

Are you on a special diet? □ Yes □ No Since: ___/___/_____ Do you smoke? □ Yes □ No

Do you wear: □ Heel lifts □ Sole lifts □ Inner soles □ Arch supports

Are you pregnant? □ Yes □ No How long? ______________

CONSENT

- We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient.
- 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 to the information I have provided.

Signature: ____

For office Use: Height: Pulse:
Weight: BF%
BP:

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