PATIENT INFORMATION

PATIENT

NAME ___________________________ ADDRESS ______________________________________
CITY ____________________________ STATE _________________ ZIP ____________________
HOME PHONE __________________________ CELL PHONE _____________________________
EMAIL ADDRESS ____
BIRTHDATE _________________________ AGE _____________ GENDER Male/Female
NUMBER OF CHILDREN ___________
OCCUPATION ________________________ EMPLOYER __________________________________
WORK ADDRESS ___________________________________ WORK PHONE ___________________
TYPE OF WORK _______________________________
MARITAL STATUS Married/Single/Divorced/Separated/Widowed
SOCIAL SECURITY NUMBER ______________________________
DRIVER'S LICENSE NUMBER ______________________________

SPOUSE OR PARENT

NAME______________________________ EMPLOYER _______________________________
WORK PHONE ___________________________ CELL PHONE __________________________

EMERGENCY CONTACT INFORMATION

NAME _____________________________________ RELATIONSHIP _________________________
HOME PHONE ___________________________ CELL PHONE _____________________________

HEALTH CONDITIONS

PLEASE CIRCLE ANY OF THE DISEASES OR CONDITIONS THAT THE PATIENT HAS NOW OR HAS HAD IN THE PAST:

HEADACHES SINUS CONDITIONS DIZZINESS LOSS OF SLEEP PAIN BETWEEN SHOULDERS NECK PAIN NUMBNESS IN HANDS OR FEET LOW BACK PAIN DIGESTIVE CONDITIONS ULCERS COLITIS STROKE HEART ATTACK CONGENITAL HEART DEFECT HEART SURGERY HEART MURMUR CANCER ASTHMA HIGH/LOW BLOOD PRESSURE DIFFICULTY BREATHING ARTHRITIS ALCOHOL/DRUG ABUSE HIV/AIDS DIABETES TUBERCULOSIS SHINGLES KIDNEY CONDITIONS CHEMOTHERAPY ANEMIA RHEUMANTIC FEVER PSYCHIATRIC CONDITIONS THYROID CONDITIONS MARFAN'S DISEASE EHLER-DANLOS DISEASE AUTOSOMAL POLYSYCSTIC KIDNEY DISEASE OSTEOGENESIS PERFECTA OTHERS:_____________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CONDITION THAT IT PERTAINS TO:

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LIST ALL MUSCULO-SKELETAL INJURIES, SURGERIES, AND/OR SERIOUS HEALTH AILMENTS EXPERIENCED IN THE PAST FIVE YEARS AND TREATMENT INVOLVING THOSE EVENTS:

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PLEASE LIST ANY AND ALL ALLERGY INFORMATION:

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DO YOU SMOKE? YES/NO?
DO YOU DRINK ALCOHOL? YES/NO?
DO YOU DRINK COFFEE? YES/NO?
DO YOU EXERCISE? YES/NO?

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN COLLECTING FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT.

I HEREBY AUTHORIZE THE DOCTOR TO WORK WITH MY CONDITION THROUGH THE USE OF ADJUSTMENTS TO MY SPINE OR EXTREMITY AS HE OR SHE DEEMS APPROPRIATE.

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I AGREE THAT I AM RESPONSIBLE FOR ALL BILLS INCURRED IN THIS OFFICE. THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISTING MEDICALLY DIAGNOSED CONITIONS NOR ANY MEDICAL DIAGNOSIS. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BECOME IMMEDIATELY DUE AND PAYABLE. I HEREBY AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS (IF APPLICABLE) DIRECTLY TO THE PROVIDER FOR SERVICES RENDERED.

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PATIENT'S SIGNATURE DATE GUARDIAN SIGNATURE DATE