WELCOME TO OUR OFFICE—PLEASE BE COMPLETE

Patient Information

Date _____

SSN (Required for insurance) _____

Patient Name _____
Last Name

_____
First Name Middle Name

Address _____

City _____

State _____ Zip _____

Email _____

Sex : Male Female Age _____

Birthdate _____

Please Circle Answer:

Married Widowed Single Minor Separated

Divorced Partnered for___years Occupation _____

_____

Employer/School _____

Employer/School Phone _____

Spouse's Name _____

Do you have children? _____

If yes, how many?_____

Whom may we thank for referring you?_____

If not personally referred, how did you hear about our office?

_____

Insurance

Who is responsible for this account? _____

Relationship to patient _____

Insurance Company _____

Group # _____

Subcriber id # _____

Insured's name _____

Insured's Birthdate _____

Insured's SSN _____

Insured's relationship to patient _____

Is patient covered by additional insurance? Yes No

Insurance company _____

Group # _____

Insured's info _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Comfort Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number (s) _____

Medical Doctor Information

Who is your family medical doctor? _____

Name of their office _____

Office Address _____

Permission to send them report YES NO

Patient Condition

What symptoms are you having? _____

When did your symptoms appear and how?_____

Is this condition getting progressively worse? _____

Rate the severity of your pain an a scale from 0 (no pain) to 10 (severe pain). _____

Type of pain, circle all that apply: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Swelling

Is the pain constant or does it come and go? _____Is it worse in the morning or evening? _____

Does it interfere with your (circle all that apply): Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform (circle all that apply): Sitting Standing Walking Bending Lying Down

Health History - Please Complete Thoroughly

What treatment have you already received for your condition? _____

_____

Name of Doctor (s) who have treated you for your condition _____

Have you had prior chiropractic care? If so, when were you last seen? _____

_____

Date of last: Physical Exam _____ Spinal X-ray _____ Blood Test _____

Urine Test _____ MRI _____ CT/Bone Scan _____

Please circle any conditions you currently have or have had in the past.

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia	Appendicitis
Arthritis	Asthma	Bleeding Disorder	Breast Lump	Bronchitis	Bulimia
Cancer	Cataracts	Chicken Pox	Diabetes	Emphysema	Epilepsy
Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart Disease
Hepatitis	Hernia	Herniated Disk	Herpes	High Cholesterol	Kidney Disease
Liver Disease	Measles	Migraines	Miscarriage	Mono	Mulitple Sclerosis
Mumps	Osteoporosis	Pacemaker	Parkinson's	Pinched Nerve	Pneumonia
Polio	Prostate Problems	Prosthesis	Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever
Scarlet Fever	Stroke	Suicide Attempt	Thyroid Problems	Tonsilitis	Tuberculosis
Tumors	Typhoid Fever	Ulcers	Vaginal Infection	Venereal Disease	Whooping Cough

Please Circle any conditions that a family member has or has had:

Scoliosis	Disc Herniations	Heart Disease	Headaches	Arthritis	Stroke

EXERCISE - Please circle

None
Light
Moderate
Heavy
Working with Trainer

WORK ACTIVITY

Sitting	Twisting
Standing	Computer Work
Light Labor	On Telephone
Heavy Labor	Distance Driving
Lifting	Flying/Travel

HABITS

Smoking	packs/day_____
Alcohol	Drinks/week_____
Coffee/Caffeine Drinks	Cups/Day _____
High Stress Level	Reason_____
Eating	#meals per day_____

FEMALES ONLY:

Are you or could you be pregnant? If so, when is your due date? _____

Do you have regular menstrual cycles? _____

Are your menstrual cycles painful or abnormal? _____

With prior births did you have difficulty with delivery? _____

Please list all Injuries and/or surgeries you have had: Date (s)

Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Car Accidents	_____	_____

Medications	Allergies	Vitamins/Supplements