WELCOME

one — ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____________________
LAST FIRST MI

What You Prefer To Be Called: ____________ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ______ SS#: ________

Mailing Address: ____________________

CITY STATE ZIP

Home Phone #: (______) ____________

Work Phone #: (______) ____________ Ext: ______

Cell Phone #: (______) ____________

E-mail Address: ____________________

Referred By: ____________________

Employer: ____________ How Long? ______

Employer's Address: ____________________

CITY STATE ZIP

Occupation: ____________________

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____________________

Do you have children? ❑ Yes ❑ No How many? ______

two — INSURANCE INFO

Primary Insurance

Co. Name: ____________________

Address: ____________________

CITY STATE ZIP

Phone #: (______) ____________

Insured's ID#: ____________________

Group # (Plan, Local, or Policy #): ____________

Insured's Name: ____________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ____________________

Secondary Insurance

Co. Name: ____________________

Address: ____________________

CITY STATE ZIP

Phone #: (______) ____________

Insured's ID#: ____________________

Group # (Plan, Local, or Policy #): ____________

Insured's Name: ____________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ____________________

three — ACCOUNT INFO

Person ultimately responsible for account

Name: ____________________

Relation: ____________________

Billing Address: ____________________

CITY STATE ZIP

SS #: ____________________

Drivers License #: ____________________

Work Phone #: (______) ____________

Payment method: ❑ Cash ❑ Check

____________________ ___/___

❑ Credit Card - Enter card # above (if accepted)

______
Initials

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).

four — IN EVENT OF EMERGENCY

Whom should we contact? ____________________

Relation: ____________________

Home Phone #: (______) ____________

Work Phone #: (______) ____________

Cell Phone #: (______) ____________

Who is your Medical Doctor? ____________________

Medical Doctor's Phone #: (______) ____________

PLEASE CONTINUE ON BACK

five 5

REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness

Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity

When did your condition/accident occur? ___/___/___ Where did your injury occur? ___________

Please explain what happened: ___________

Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.

Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: ___________

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: ___________

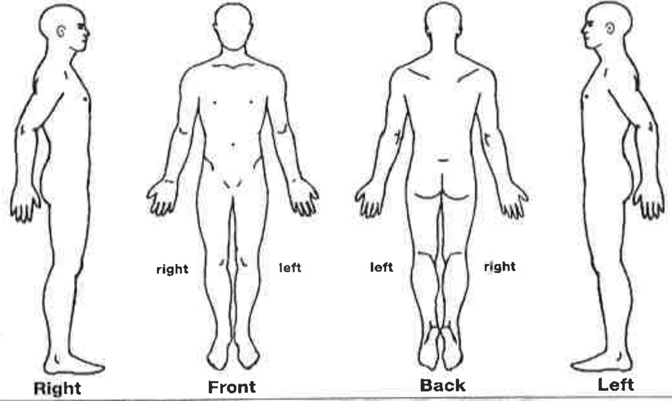
Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? ___________

Have you ever been treated by a Chiropractor? ❑Yes ❑No

Clinic or Dr's name: ___________

Clinic phone#: ___________



six 6

HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ___________

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis	**Y N** HIV+ / AIDS / ARC
Y N Shingles	**Y N** Cancer	**Y N** Frequent Neck Pain	**Y N** Glaucoma	**Y N** Anemia / Diabetes
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe / Frequent Headaches	**Y N** Kidney Problems
Y N Ulcers / Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema / Asthma	**Y N** Tuberculosis
Y N Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: ___________

List any past serious accidents with dates: ___________

Please list anything that you may be allergic to: ___________

Family Health History: ___________

Do you take Supplements or Vitamins? ❑ Yes ❑ No   Do you exercise? ❑ No ❑ Yes ____ hours per week

Do you smoke? ❑ No ❑ Yes How much? ________ How long? ________

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports   Are you dieting: ❑No ❑Yes Since: ___/___/___

For woman: Are you taking Birth Control? ❑ Yes ❑ No

Are you Nursing? ❑ Yes ❑ No   Are you Pregnant? ❑ No ❑ Yes   If so, how many weeks? ________

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- 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 date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other 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 to the information I have provided.

Signature ____________________ Date ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials ______ Date ___/___/___
Comments ______

Initials ______ Date ___/___/___
Comments ______

Initials ______ Date ___/___/___
Comments ______

First Impression Forms, Inc. 1-800-99FORMS FORM # 2MCA1 Copyright ©2004