

FILL OUT COMPLETELY - PLEASE PRINT

Name _____ Birth Date _____ SS# _____

Address _____ City _____ State _____ Zip _____

Marital Status _____ Hm Phone _____ Wk Phone _____ Cell# _____

Employer _____ Occupation _____ Email Address _____

Spouse's Name _____ Occupation _____ Ladies, are you pregnant? Yes No

How did you hear about us? Phone Book Ad Sign Referral-Their Name _____

Chiropractic Before Y N If yes, when? _____ Doctors Name _____

Briefly describe complaints _____

Other doctors seen for complaint _____ When _____

Are complaints caused by Auto Accident? Yes No (If yes, ask for auto form to fill out)

List All surgeries and dates _____

List All drugs being taken and for what _____

List All vitamins you're taking _____

Have you ever been diagnosed as having or suffering from:

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Broken bones or fractures | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Depression |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Ruptures |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Head Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Cancer | Other _____ |

Payment Arrangements: (Check One) Cash/Check Credit Card Insurance (Must be verified in Advance)

READ CAREFULLY - IF YOU UNDERSTAND AND AGREE, SIGN BELOW

Authorization & Assignment: I hereby authorize and assign any and all insurance and/or third party benefits directly to this office. I authorize the release of any and all information he deems necessary to anyone in order to process a claim for insurance or third party benefits on my behalf, and hereby release him of any consequences thereof.

I hereby authorize the doctor to treat my condition(s) as he deems appropriate through the use of spinal adjustments (manipulation) and therapy throughout my spine/body. I understand and agree the amount paid the doctor for x-rays, is for the examination and analysis of the x-rays only and the x-ray negatives will remain the property of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or medical diagnosis. I understand and agree that I am responsible for any and all charges at this office whether paid by insurance or not.

I give this office consent to treat me and or my minor children. All information is true and accurate to the best of my knowledge.

Signature _____ Date _____
(Patient - Guardian)