Choice
Chiropractic & Wellness Center

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PATIENT INFORMATION/APPLICATION FOR CARE

(The following information is needed to better serve you. Please complete all questions. If you need help please ask.) **PLEASE PRINT.**

Date: _____ Name: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ Male / Female (circle) Your SS#: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Occupation: _____ Employer: _____ Years on job _____

Employer Address: _____City: _____ State: _____ Zip: _____

Driver License. # _____ Insurance Company _____

Do you have Medicare? Yes _____ No _____ Medicaid? Yes _____ No _____

Status: (circle) Single Married Divorced Separated Widowed Minor Children: Yes / No How many? _____

Spouse's name: _____ Birth date: _____ Age: _____

Spouse's occupation: _____ Employer: _____

Years on Job _____ Work phone: _____

How payment will be made: _____Cash _____Check _____Credit Card _____Health Insurance _____ Auto Ins. Policy _____Workman's Comp.

Have you ever been in an Auto Accident? _____Past year _____Past 5 Years _____ Over 5 Years _____ Never

How did you hear about us? : _____

REASON FOR YOUR VISIT

COMPLETE THESE DIAGRAMS

Please mark the exact location of your pain on the adjacent diagram. Also, describe the type and frequency of your pain, as well as any activity that brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

Major Complaints

(Please list any condition(s) you are experiencing.)

_____

_____

_____

_____

_____

_____

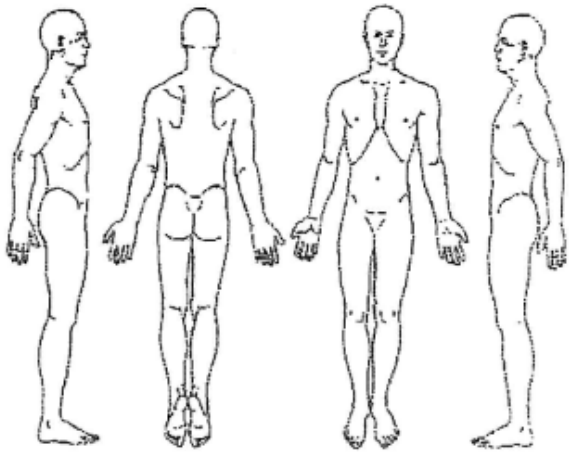
_____

_____

_____

_____

MARK LOCATION(S) OF PAIN BELOW



EMERGENCY CONTACT

Who should we contact: _____ Relation: _____

Cell Phone: _____ Work Phone: _____

Who is your Medical Doctor? Phone:

HEALTH HISTORY

Circle any of the following diseases, medical conditions or procedures that you have or have had in the past:

Alcohol/Drug abuse	Dizziness	High/Low blood pressure	Osteoporosis	Ulcers
Allergies	Epilepsy/Seizures/Fainting	HIV / AIDS	Pacemaker	Upper back pain
Anemia/Diabetes	General muscle fatigue	Implants/Artificial joints	Polio	Venereal Disease
Arthritis	Glaucoma	Joint swelling/stiff	Rheumatic Fever	Psychiatric problems
Asthma	Gout	Kidney problems	Shingles	Birth Control
Cancer	Headaches	Low back pain	Shoulder pain	Hormone replacement
Congenital Heart Defect	Hepatitis	Mid-back pain	Stroke/Heart attack	**Currently Pregnant**
Congestive Heart Failure	Herniated Disc	Neck pain	Tuberculosis	Yes / No DUE: _____

List Current Medications/Supplements: ☐ **Check If None**_____

_____

List Past Surgeries/Accidents, etc: ☐ **Check If None** _____

_____

LIFESTYLE HISTORY

Exercise:	YES	NO	_____ Hours/Week	
Tobacco Use:	YES	NO	How Long? _____	_____ Packs/Week
Smokeless Tobacco Use:	YES	NO	_____ Cans/Week	
Alcohol Use:	YES	NO	_____ Drinks/Week	
Do you drink 8 (8oz) Glasses of Water Daily:	YES	AT LEAST	NO	

I, the undersigned, do hereby attest that this questionnaire has been completed truthfully and to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information I have provided. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that insurance policies are a contract between the insurance company and the policy holder, not the doctor, and as such I am responsible to know any policy limitations that might exist. On all insurance assignments the deductible, if applicable, must be met first unless prior arrangements are made. Further, if the services of a collection agency become necessary to collect the balance on my account, any associated fees are my responsibility.

Patient's signature: _____ Date: _____

Or Guardian's signature: _____ Date: _____

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

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