

Today's date: _____

■ **Who are you?**

Patient's name: _____

Address: _____

City, state & zip: _____

Home phone: _____ Cell: _____

Social security number: _____

Birth date: _____ Age: _____

E-mail address: _____

■ **Who do we contact in case of an emergency?**

Contact: _____ Phone: _____

Where would you prefer to be contacted? _____

■ **Are you employed?**

If so, employer: _____ Phone: _____

Address: _____

■ **Do you have a family doctor or dentist?**

Family doctor: _____

Phone: _____

Family dentist: _____ Phone: _____

Whom may we thank for referring you: _____

Previous chiropractor: _____

I will be paying by: Cash Check MasterCard Visa Discover

Would you like to receive our e-mail newsletter? Yes No

■ **Do you experience any of these health problems?**

- Headaches Pulled muscles Car accident Sinus pain/allergies
- Sleeping problems Stressed shoulders Leg & hip pain Scoliosis
- Emotional stress Wrist or joint pain Neck pain Stiffness
- Numbness Work injury Lower back pain Stomach/digestive trouble
- Mid-back pain Loss of energy Lack of exercise Frequent colds/flu

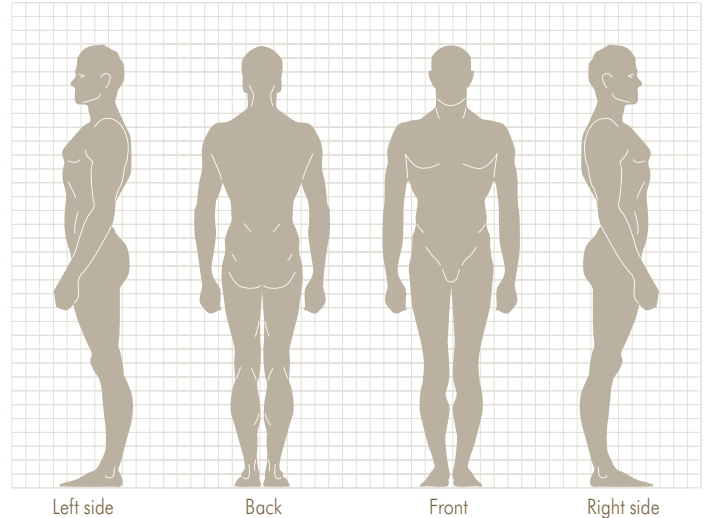
Current health problems: _____

Currently taking medications: _____

Do these conditions interrupt...

- Career Sleep pattern Ability to exercise Family life Social life

Where are your problem areas?



What methods have you tested?

- Exercise Physical therapy Prescription drugs Massage Nothing

What's your condition:

How long have you been living this way? Weeks: _____ Months: _____ Years: _____

Would you like to find the cause of your problem(s)? Yes No Maybe

What results would you want for yourself?

- Reduce pain Restore health Maintain health

Signature of Agreement

I understand and agree that health insurance is an agreement between the carrier and myself. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable.

Signature: _____ Date: _____

Acknowledgement of HIPPA Privacy Act

My signature acknowledges I have read and understand the HIPPA Act.

Signature: _____ Date: _____

Personal representative name printed: _____

Personal representative signature: _____

Relationship to patient: _____ Date: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare/Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be confidential.