

CHROPRACTIC ASSOCIATES

PLEASE PRINT

GENERAL INFORMATION:

Patient Last Name: _____ First Name: _____

Address: _____ Care of: _____

City: _____ State: _____ Zip: _____ Native Language: _____
(financially responsible person)

Email: _____ Driver Lic. #: _____ State: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: Male Female Married Single Widowed Divorced Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

Patients' Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Occupation: _____ Full Time Part Time Retired Not Employed Student Part time Full Time

Spouse's Name: _____ Spouse's Employer: _____

Of Children: _____ Employer's Phone: _____

INSURANCE INFORMATION COMMERCIAL INSURANCE AND MEDICARE ONLY

Primary Insurance Company Name: _____ Type Group Private

Member #: _____ Policy/Group #: _____

Secondary Insurance Company: _____ Member #: _____ Policy/Group #: _____

COMPLETE ONLY IF PATIENT IS NOT THE INSURED:

Insured's Name: _____ Patient relationship to insured: _____

Insured's DOB: ____ / ____ / ____ Insured's Employer: _____

Male Female Married Single Widowed Divorced

AUTOMOBILE ACCIDENT / WORKERS COMPENSATION ONLY

Insurance Company Name: _____ Claim #: _____ Policy #: _____

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

Adjuster's Name: _____ Phone: _____

Attorney's Name: _____ Phone: _____

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature: _____ Date: _____

Chiropractic Associates

Patient History

Please complete the entire form. All information collected is kept confidential.

Name: _____ Date: _____

Major Complaint:

How long have you had this condition? _____ Date of onset: _____
Have you lost work days? Yes No If yes, how many days lost? _____
Have you had this similar condition before? Yes No If yes, when? _____
Is the main complaint accident related? Yes No
If yes, when was the accident? _____ Auto accident Work accident
List the date of all auto accidents: _____

Have you had any previous Chiropractic care? Yes No

What was the reason for your initial visit to a Chiropractor? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

Did you follow the program? Yes No If no, why? _____

Why are you changing Chiropractors? _____

List and date all surgeries you have had: _____

List all prescription and non-prescription drugs you are taking: _____

Name other Doctors you have seen for this condition: _____

What are your health goals?

How do you plan to achieve these goals? _____

Place a check mark if you have experienced any of these symptoms in the last 12 months.	
<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Neck pain or stiffness L or R <input type="checkbox"/> Asthma
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Numbness, tingling pain in arms, hands or fingers L or R <input type="checkbox"/> Chest pain
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw pain or popping L or R <input type="checkbox"/> Heart problems
<input type="checkbox"/> Convulsions, epilepsy	<input type="checkbox"/> Difficulty in excessive standing, sitting, riding, bending, lifting, or twisting <input type="checkbox"/> Stroke
<input type="checkbox"/> Skin problems	<input type="checkbox"/> High/low blood pressure
<input type="checkbox"/> Cancer- type: _____	<input type="checkbox"/> Liver trouble
<input type="checkbox"/> Frequent colds or flu	<input type="checkbox"/> Gall bladder trouble
<input type="checkbox"/> Depression	<input type="checkbox"/> Digestive problems
<input type="checkbox"/> Irritability	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Anemia	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Allergy, sinus	<input type="checkbox"/> Impotence
<input type="checkbox"/> Stress	<input type="checkbox"/> Kidney trouble
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Menstrual problems, PMS
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Currently Pregnant
<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Ringing in ears L or R	<input type="checkbox"/> Ear infections
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> AIDS, HIV

I fully understand I am solely responsible for any balance not paid by my insurance company. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organizations to release any information required to process insurance claims. The above information is true and accurate to the best of my knowledge.

Patient Signature

Date

Chiropractic Associates

705 W. John Sims Parkway
Niceville, Florida 32578
(850)678-8048

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature) _____ *(date)*

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

(signature) _____ *(date)*