

ADVANTAGE CHIROPRACTIC

Dear Patient,

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do sincerely believe your condition will respond satisfactorily, we will accept your case. Thank you.

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Telephone() _____ Alternate Number() _____

What you prefer to be called _____ **How were you referred to us?** _____

Employer/Occupation _____ Work Number() _____

Sex: (M)____(F)____ Birth date: ____/____/____ Age: ____ Social Security #: ____-____-____

Marital Status: M S W D Spouse's Name: _____ Number of Children _____

Nearest Relative: _____ Telephone # () _____

Name of Primary Physician: _____ Telephone # () _____

Email Address: _____

Have you ever seen a Chiropractor before? Y N If yes, when and who? _____

HEALTH INFORMATION

What is your major complaint? _____

Other complaints? _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

What areas of your life have been affected by your pain and symptoms? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ___ No ___ Constant ___ Comes and Goes ___

Is this condition interfering with your: Work ___ Sleep ___ Daily routine ___ Other ___

How long has it been since you've felt good? _____

List other doctors who have treated this condition _____

List surgical operations and years _____

Drugs you now take: Nerve pills _____ Pain Killers _____ Muscle relaxers _____ "Pep"pills _____

Tranquilizers _____ Birth control _____ Others _____

Are you pregnant? Yes ___ No ___ How far long? _____ Nursing? Yes ___ No ___

Age of Mattress _____ Comfortable _____ Uncomfortable _____

Are you wearing: Heel lifts _____ Sole lifts _____ Inner soles _____ Arch supports _____

Have you been in an Auto Accident? Past year ___ Past 5 years ___ Over 5 years ___

Describe: _____

Please mark your areas of pain on the

HAVE YOU EVER SUFFERED FROM:

Figures below:

1. Dizziness _____
2. Backaches _____
3. Heart Troubles _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

INSURANCE INFORMATION:

Are your conditions due to an auto accident or job related injury? Yes _____ No _____

Do you have Health Insurance? Yes _____ No _____

If yes, Name of the Company _____

Policy # _____

Does Medicare cover you? Yes _____ No _____ If yes, Medicare policy # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

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 for by my insurance company (if offered at this office).

Patient's Signature _____ **Date** _____

Guardian or Spouse's Signature _____ **SS#** _____

Doctor's Signature _____