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 ( ) ________________________Cell 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? ____________________________

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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____

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Drugs you now take: Nerve pills______ Pain Killers______ Muscle relaxers_____

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

Figures below:

HAVE YOU EVER SUFFERED FROM:

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 ____

Doctor's Signature ____