



## General Patient Information

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

What You Prefer To Be Called: \_\_\_\_\_ Male/Female: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City

State

Zip

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Other Phone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How long employed? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City

State

Zip

Occupation: \_\_\_\_\_

### Insurance

Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City

State

Zip

Phone#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insured's ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

### In Event Of Emergency

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ Phone #: \_\_\_\_\_

# Chiropractic Wellness Center

## Account Information

Person ultimately responsible for account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

City

State

Zip

D.L.#: \_\_\_\_\_ Work Phone#: \_\_\_\_\_ Payment method:    Cash        Check

\_\_\_\_\_ By initialing, 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 by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_  
Adult Patient    Parent or Guardian    Spouse

Date \_\_\_\_\_

## Chiropractic Wellness Center

### CONTEXT OF CARE

Please take the time to answer these questions honestly and thoughtfully. With your answers, I can tailor my treatment for you so that you receive the most benefit from it.

- ❖ Why did you choose to come to this clinic?
  - What do you know about my approach?
  
- ❖ What three expectations do you have from this visit to our clinic?
  - What long-term expectations do you have from working with our clinic?
  
  - What expectations do you have of me personally as your doctor?
  
- ❖ What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed.)

0    1    2    3    4    5    6    7    8    9    10
  
- ❖ What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list.)
  
- ❖ What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list.)
  
- ❖ What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that I will be sharing with you?
  
- ❖ Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?
  
- ❖ What do you LOVE to do?

## Chiropractic Wellness Center

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### HEALTH HISTORY QUESTIONNAIRE

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Name:		Phone:				
Previous referring doctor:		<input type="checkbox"/> M <input type="checkbox"/> F Age:		DOB:		
Other health care providers:			Date of last physical exam:			
What brings you into the office today?						
What are your expectations?						
Prescription (Rx) meds?			Supplements?			
Past surgeries?			Medication Allergies?			
<b>PERSONAL HEALTH HISTORY</b>						
Childhood illness:						
Immunizations: <input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis <input type="checkbox"/> Influenza <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chickenpox <input type="checkbox"/> MMR						
List any medical problems that other doctors have diagnosed:						
<b>HEALTH SCREENING EXAMS</b>						
Please mark all you have had and the approximate date/year of the test.						
Chest X-ray:		CT scan:	EKG:	Stress Test:	Echocardiograms:	MRI:
Blood Testing:		Colonoscopy/Sigmoidoscopy:			Other:	
Women:	PAP Smear:		Mammogram:		Pelvic Ultrasound:	
Men:	Prostate Exam:			PSA Blood Test:		
<b>FAMILY HISTORY</b>						
Have any blood relatives been diagnosed with the following (Please mark all that apply and family relation.)						
Alcoholism:		Cancer:		Mental Health Problems:		
Alzheimer's:		Depression:		Migraines:		
Arthritis:		Diabetes:		Osteoporosis:		
Autoimmune disorders:		Heart Disease:		Thyroid Problems:		
Bleeding Disorders:		High Blood Pressure:		Colon/Digestive:		
Cataracts/Glaucoma:		Kidney Disease/Stones:		Stroke:		
<b>SOCIAL HISTORY</b>						
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed						
Do you live:    alone    with children    spouse    roommate    significant other ( male / female )						
Do you have children:		Y	N	If so, how many?		
Do you sleep well?		Y	N	What are your hobbies?		
How is your energy level?		Poor	Fair	Good    Excellent		
Are you sexually active?		Y	N	If yes, are you trying for a pregnancy?    Y    N		
Do you smoke/chew?		Y	N	How much?		
How much alcohol do you drink?						
Do you currently use recreational or street drugs?		Y	N	In the past?    Y    N		

