Schadow Chiropractic

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www.schadowchiro.com

CHIROPRACTIC ACUPUNCTURE MASSAGE THERAPY

ABOUT YOU

Today's Date _____

Patient's Name _____
First MI Last

What You Prefer To Be Called _____

Birthdate ____/____/____ Age _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone ( )_____Work Phone ( )_____ Ext. _____

Cell Phone # ( )_____

Email _____

Referred By_____

☐ Friend/Relative ☐ Insurance ☐ Doctor ☐ Attorney ☐ Internet ☐ Yellow Pages ☐ Other

Employer _____ How Long? _____

Employer's Address _____

City _____ State _____ Zip _____

Occupation _____

Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name _____

Do You Have Children? ☐ Yes ☐ No How Many? _____

INSURANCE

Company Name _____ Phone ( )_____

Address _____

City _____ State _____ Zip _____

Insured's ID# _____Group # (Account or Claim #) _____

Insured's Name _____ Relation ☐ Self ☐ Spouse ☐ Child ☐ Other

Date Of Birth ____/____/____

Please inform the front desk of 2nd insurance source

REASON FOR VISIT

The reason for this visit is a result of ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic ☐ Other

Explain what happened _____

_____

Please describe the pain and its location _____

_____

When did condition begin? ____/____/____

Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine

If so, please explain _____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so,where? _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, whom? _____ Phone ( )_____

Please Continue On Back

IN EMERGENCY

Who should we contact? _____

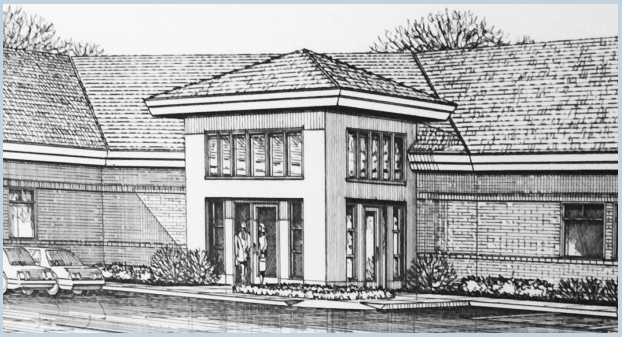
Relation? _____

Home Phone ( )_____

Work Phone ( )_____

Who is your medical doctor? _____

Phone ( )_____



HEALTH HISTORY

Are you taking any of the following medications? ☐ Pain Medication (including aspirin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	**Y N** Heart Surg/Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect
Y N Mitral Valve Prolapse	**Y N** Artificial Valves	**Y N** Alcohol/Drug Abuse	**Y N** Venereal Disease
Y N Hepatitis	**Y N** HIV+/Aids	**Y N** Shingles	**Y N** Cancer
Y N Chemotherapy	**Y N** Frequent Neck Pain	**Y N** Emphysema/Glaucoma	**Y N** Anemia
Y N Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Diabetes/Tuberculosis	**Y N** Difficulty Breathing
Y N Kidney Problems	**Y N** Ulcers/Colitis	**Y N** Sinus Problems	**Y N** Asthma
Y N Lower Back Problems	**Y N** Artificial Bones/Joints	**Y N** Arthritis	**Y N** Severe/Frequent Headaches
Y N High/Low Blood Pressure	**Y N** Fainting/Seizures/Epilepsy		

Please list any other serious medical condition(s) you have or ever had _____

_____

Please list anything you may be allergic to _____

List previous surgeries/treatments with dates _____

_____

List any **past** serious accidents with dates _____

Family Health History _____

_____

Do you take any supplements or vitamins? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No Since?_____

Do you smoke? ☐ Yes ☐ No How much?_____ How long? _____

Are you wearing arch supports ☐ Yes ☐ No

What is the age of your mattress? _____ Is it comfortable? ☐ Yes ☐ No

Do you use a conventional pillow? _____ Is it comfortable? ☐ Yes ☐ No

For Women: Are you taking birth control?☐ Yes ☐ No Are you pregnant?☐ Yes ☐ No How long? _____Are you nursing? ☐ Yes ☐ No

- 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 in 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 authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims.
- 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.
- I acknowledge that HIPPA policies were available to me to review during the admission process at Schadow Chiropractic.

SIGNATURE_____**DATE**_____