Welcome to Dynamic Chiropractic Clinic

one About you

Today's date: ____/____/_____ File #: _____

Name: _____ What do you prefer to be called? : _____

Male ☐ Female ☐ Birth Date: ____ /____ / _____ Age: ____ SSN: _____- ____ - _____

Mailing Address:

_____

Street City State Zip Code

Home phone #: _____ Other Phone #: _____

Email address: _____

Who can we thank for referring you?: _____

Who is your employer?: _____

Employer's address:

_____

Street City State Zip Code

Occupation: _____ Marital Status: ☐ Single ☐ Divorced ☐ Separated

☐ Married ☐ Widowed ☐ Partnered ---- Spouse's name: _____

two The reason for your visit

Please explain the primary reason for visiting our office: (Please explain what happened)

_____

_____

Was this the result of (**circle one**): auto accident, sports, work injury, trauma or chronic problem?

Please describe your pain (if any) and its location:

_____

_____

When did this begin? (date) ____ /____ /_____ Is the problem getting worse? ☐Yes ☐No

Would you describe the problem as (**circle one**)getting better, getting worse, constant, comes and goes?

Is the problem interfering with your **work, sleep, daily routine**? If so, please describe:_____

_____

Have you ever had this condition before? ☐ Yes ☐ No If so, please describe when and how: _____

_____

three In event of emergency

Who should we contact? _____

Relation: _____

Home #: _____ Work #:_____

Who is your medical doctor? : _____ Phone #: _____

four Your health team

Medical Doctor: _____ Phone/Facility: _____
Massage Therapist: _____ Phone/Facility: _____
Acupuncturist: _____ Phone/Facility: _____
Physical Therapist: _____ Phone/Facility: _____
Dentist: _____ Phone/Facility: _____
Personal Trainer: _____ Phone/Facility: _____
Other: _____ Phone/Facility: _____

Health history

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐Muscle relaxants ☐ Stimulants ☐ Blood thinners
☐ Tranquilizers ☐ Insulin ☐ Other(s):_____

Have you had any of the following condition(s)?

☐Artificial Valves	☐ Heart Attack/Stroke	☐ Lower Back Problems
☐ Alcohol/ Drug Abuse	☐ Emphysema / Glaucoma	☐ Shingles
☐ Anemia	☐ Fainting/Seizures/Epilepsy	☐ Sinus Problems
☐ Arthritis	☐ Frequent Mid-Back Pain	☐ Indigestion
☐ Artificial Bones/Joints	☐ Frequent Neck Pain	☐ Mitral Valve Prolapse
☐ Asthma	☐ Heart Surgery	☐ Psychiatric Problems
☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever
☐ Congenital Heart Defect	☐ Hepatitis	☐ Severe/Frequent Headaches
☐ Chemotherapy	☐ HIV+ / AIDS	☐ Ulcers/Colitis
☐ Diabetes/Tuberculosis	☐ Kidney Problems	☐ Venereal Disease
☐ Difficulty Breathing		

Please list any other serious medical condition you have or ever had:
_____
Please list anything you may be allergic to:
_____
Please list any surgeries you may have had:
_____
Please list any past serious accidents with date(s):
_____
Family Health History (Diabetes, High Blood Pressure, etc.):
_____

Do you smoke? ☐ No ☐ Yes/ How much? _____ For how long? _____Are you wearing: Heel lifts Sole lifts
How old is your mattress? _____ Is it comfortable? _____
For women: Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No ☐ Not sure
Are you nursing? ☐ Yes ☐ No
Is there something you feel the doctor should know before treatment? :_____

Account Info five

Person ultimately responsible for this account:

Name: _____ Relation: _____
Billing address: _____
Street City State Zip Code
SSN: _____ Driver's License #: _____
Work Phone #: _____ Payment method: Cash Check CC #_____

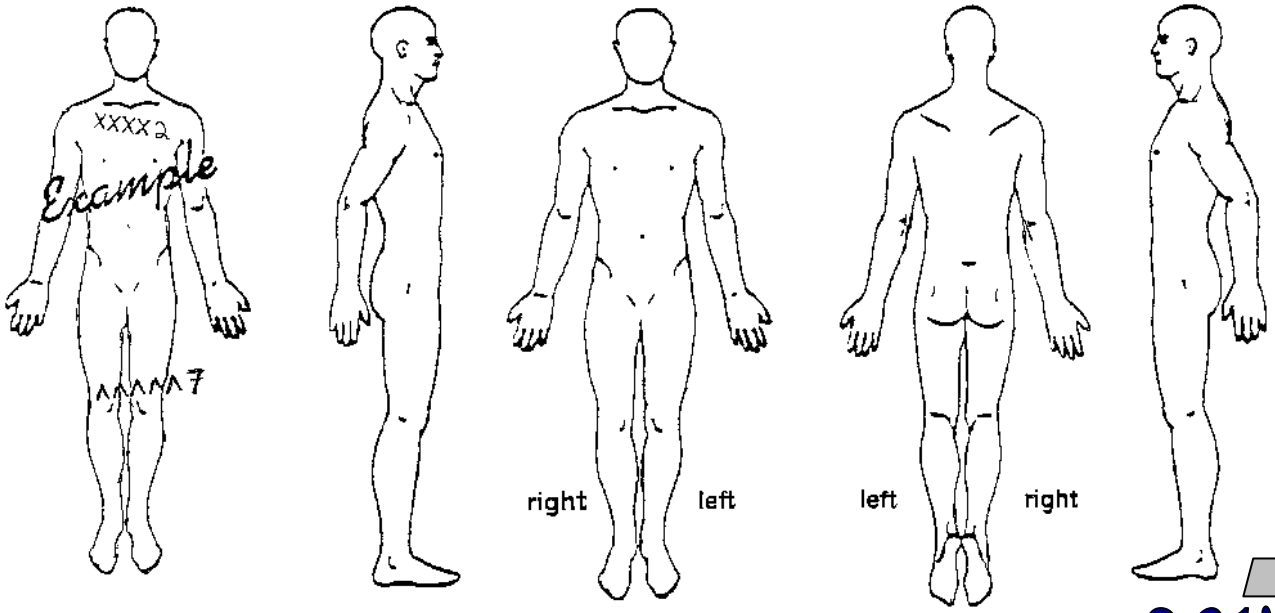
I authorize assignment of my insurance rights and benefits directly to the provider for services rendered. _____ (**initial**)

Show us where it hurts

six

1. Please show us where you are experiencing symptoms…
2. Indicate your degree of pain using a scale of **1** (minor discomfort) to **10** (extreme pain):

Numbness:	Pins & Needles:	Burning:	Aching:	Stabbing:
~~	OOOOOO	^^^^^^^	XXXXXXX	///////



seven

- We invite you to discuss with us any questions regarding your care and 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 at the time of visit, unless other arrangements have been made with the doctor. The legal part: I permit this office to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. If my account is not paid within 90 days of the date of service, whether the account has been charged to insurance or account and no financial arrangements are made, I will be responsible for any expenses incurred while collecting on my account. I also understand that if I terminate my care at *Dynamic Chiropractic Clinic*, any fees for professional services will be immediately due and payable, unless prior arrangements have been made. I hereby authorize the doctors at *Dynamic Chiropractic Clinic* and whomever they designate as their assistants to administer treatment as they so deem necessary. I also authorize the provider and / or managed care organization to release my information required to process insurance claims.

- I understand the above information and guarantee this form was completed to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my personal information and medical status.

Signature: _____ Date: _____

Thank you for choosing our clinic for your chiropractic care!

The Doctors and Staff of *Dynamic Chiropractic Clinic.*