NELSON CHIROPRACTIC & REHABILITATION

WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." ***Thomas Edison***

Patient Information

Thank you for choosing our practice for you chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name _____ Date _____ S/S _____-_____-_____
First MI Last

Address_____ Apt #_____
City _____ State _____Zip _____
Sex: ☐ Female ☐ Male
Birth date: _____ Age: _____
Home phone # _____ Work phone # _____E:Mail_____
Do you prefer to receive calls at : ☐ Home ☐ Work ☐ Either
Are you : ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated
Your employer_____ Occupation_ _____
Business Address _____ City _____ State _____ Zip _____
Spouse's or parent's name _____Workplace _____ Work phone # _____
Whom may we thank for referring you to us ? _____
Person to contact in case of emergency _____ Phone #_____

Responsible Party

Name of person responsible for this account ?_____
Relationship to patient _____Phone # _____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____
Birth date _____ Social Security # _____ Date employed _____
Name of employer _____ Work phone # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____Phone # ( ) ____- _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐ Yes IF YES PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____
Birth date _____ Social Security # _____ Date employed _____
Name of employer _____ Work phone # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone # ( ) _____- _____ Group # _____ Employer # _____

PLEASE TURN OVER AND COMPLETE PAGE 2

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____
Is this condition getting progressively worse? _____
Where specifically is the problem(s) located ? _____
Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other
Type of pain : ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
Rate the severity of your pain. (1, mild or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go?

_____

What treatment have you already received for your condition?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____
Name and address of other doctor(s) who have treated you for your condition:

_____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Mumps	☐ Stroke
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Osteoporosis	☐ Thyroid Problem
☐ Allergy Shot	☐ Chicken Pox	☐ Herniated Disc	☐ Pacemaker	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Parkinson's Disease	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Blood Pressure	☐ Pinched Nerve	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ High Cholesterol	☐ Pneumonia	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Kidney Disease	☐ Polio	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Liver Disease	☐ Prostate Problems	☐ Vaginal Infection
☐ Bleeding Disorder	☐ Glaucoma	☐ Measles	☐ Prosthesis	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Migraine Headaches	☐ Psychiatric Care	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Other _____
☐ Bulimia	☐ Gout	☐ Mononucleosis	☐ Rheumatic Fever	_____
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Scarlet Fever	_____

Date of last exams _____
(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐Yes ☐ No Taking birth control pills? ☐ Yes ☐ No
List any type of surgeries which you have had and the dates which they occurred:

_____
_____

Please list all medication you are currently taking : _____
Allergies : _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy
What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

What vitamins do you currently take? _____
What kind of other nutritional supplements do you take (if any) ? _____
Do you smoke? ☐ Yes ☐ No How much per day? _____
How much alcohol do you consume on a weekly basis? _____
How much coffee or caffeinated beverage do you consume on a daily basis? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____DATE: _____

SIGNATURE OF PATIENT (or parent if a minor)