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Patient Name:____ ☐ Male ☐ Female

LAST FIRST MI

What You Prefer To Be Called: ____________________ Birthdate: _____/_____/_____ Age: ______

SS#: ___________________________ Driver's License #___________________________

Mailing Address: ____

STREET CITY STATE ZIP

Home Phone #: (_____)________________ Cell Phone #: (_____) _________________________

Work Phone # (_____)________________ E-mail Address : ____________________________

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed - Ages of Children ____________________

Whom can we thank for referring you?____

Employer: ________________________ How Long: ___________ Occupation___________

Employer's Address: ____

STREET CITY STATE ZIP

IN EVENT OF EMERGENCY

Whom should we contact? __________________________ Relation: __________________

Home Phone #: ________________ Work#_______________ Cell #___________________

Who is your Medical Doctor? ____________________________ Phone #: (____) ____________

PAYMENT FOR CARE

☐ CASH ☐ CHECK ☐ CREDIT CARD PLUS ☐ INSURANCE, Please give us a copy of any of your Insurance Cards

ACCOUNT INFO -Person ultimately responsible for account:

Name: _______________________________ Relation: ______________________________

Address: ____

SS #: ______________________________ Drivers License #: _________________________

Home#_________________ Work #: ______________________ Cell#_________________

HEALTH HISTORY

Where or what is your main problem?____

How did it start?_________________________How long has it been bothering you?_______________

Have you had treatment for this problem, please explain:________________________________

Have you ever been to a Chiropractor before? □ yes □ no If yes, Your last Chiropractor's Name______________

Your last adjustment?__________ What was the treatment for?______________________________

Do you have or have you had any of the following diseases, medical conditions or procedures?

□ Headache □ Fainting □ Dizziness □ Twitching □ Numbness □ Migraines □ Allergies

□ Neck Pain □ Fatigue □ Glaucoma □ Sinus Problems □ Vision problems □ Ringing in Ears

□ Cold hands □ Seizures/Epilepsy □ Depression □ Irritability □ Loss of Balance □ Ear Infections

□ Pain in arms/shoulders □ Muscle spasms □ Asthma □ Chest Pain □ Mid Back Pain □ Rib Pain

□ Shortness of Breath □Thyroid trouble □ Anemia □ Pins and needles in arms or hands □ Diabetes

□ High Blood Pressure □ Kidney Problems □ Constipation □ Stomach Problems □ Ulcers/Colitis

□ Low Blood Pressure □ Congenital Heart Defect □ Heart Attack/Stroke □ Mitral Valve Prolapse

□ Cancer □ Scoliosis □Arthritis □ Artificial Bones/Joints/Implants □ Psychiatric Problems

□Lower Back Problems □ Pain down legs □ Numbness/Tingling in legs □ Other__________________

Please list any surgeries with dates :____

List any past serious accidents with dates: ____

Please list the current medications you are on and for what problem: ___________________________

Do you take Supplements or Vitamins? □ Yes □ No Do you exercise? □ No □ Yes ______ hours per week

Do you smoke?□ No □ Yes How much? _______How long? _______Are you dieting? □ No □ Yes Since ____/____/_____

Are you wearing: □ Shoe lifts □ Inner soles □ Arch supports

FOR WOMAN:
Are you pregnant? □ No □ Yes If so, how many weeks? ______ Are you nursing? □ Yes □ No

I hereby authorize the doctor and or associates of Back to Life Chiropractic to work with my condition through the use of Chiropractic adjustments and physiotherapy to my spine, as he or she deems appropriate. I authorize the staff to perform any necessary services needed during diagnosis and treatment. If care is for a minor child listed above I am giving the doctors of the facility authorization to treat my child's condition as described above. I clearly agree that all services rendered me are charged directly to me and that I am personally responsible for all bills incurred at this office. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand that the doctor's office will prepare any necessary forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt.

______________________________ ______________________________
DATE PATIENT

____
SIGNATURE OF RESPONSIBLE PARTY