

one

Welcome to

Beyond Chiropractic

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 #: _____ Cell Phone #: _____

Please tell us who referred you: _____

Who is your employer? : _____

Employer's address:

Street _____ City _____ State _____ Zip Code _____

Occupation: _____ Work Phone #: _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's name: _____

Email address: _____

Would you like to receive our e-newsletter? Y N

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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: _____

Have you sought any other treatment before this? Yes No If so, please describe: _____

Have you ever been to a chiropractor before? Yes No If so, whom? Name: _____

Where? _____ What did you enjoy most about their care?

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In event of emergency

Who should we contact? _____
 Relation: _____
 Home #: _____ Work #: _____
 Who is your medical doctor? : _____ Phone #: _____

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)?

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

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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

Account Info

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Person ultimately responsible for this account:

Name of insured: _____ Relationship to patient: _____

Billing address: _____

Work Phone #: _____ Payment method: Cash Check CC #: _____ Exp: ____

Insurance company: _____ Group #: _____ ID#: _____ Phone #: _____

Insurance company address: _____

____ I authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

(initial)

Show us where it hurts



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

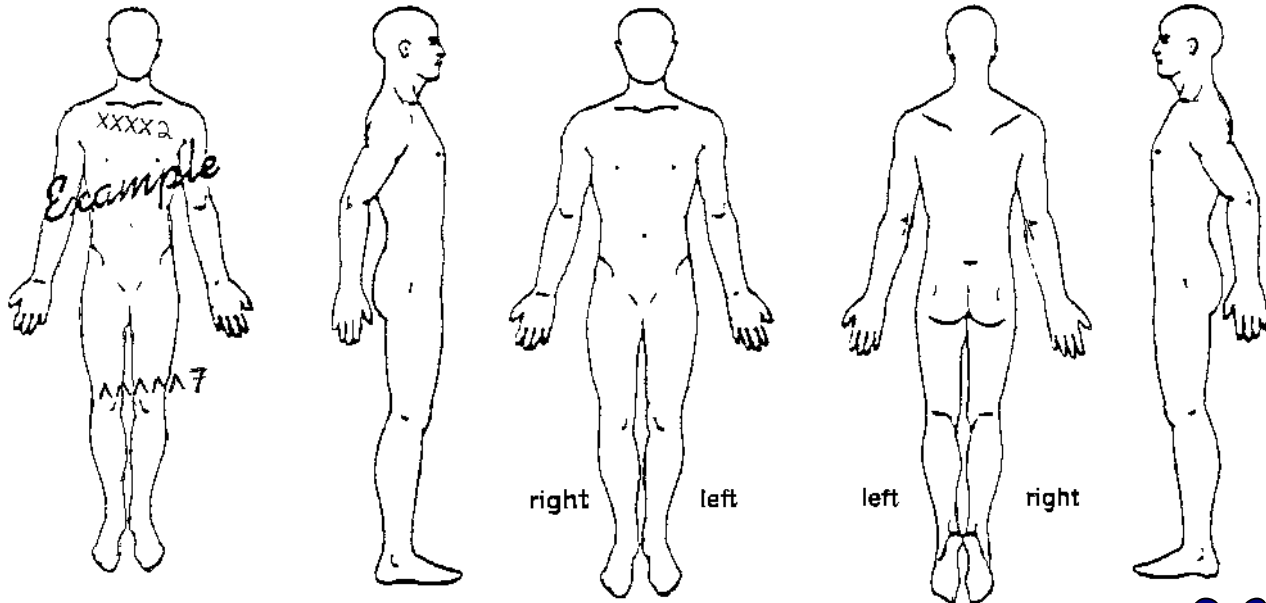
Numbness:

Pins & Needles:
 0000000

Burning:
 ^^^^^^^

Aching:
 XXXXXXX

Stabbing:
 //////////////



- ✦ 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. 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 *Beyond 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 *Beyond 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 Beyond Chiropractic clinic for your chiropractic care!