Spinal Health and Wellness Center, LLC

Chiropractic

Welcome to our Practice

Thank you for choosing our practice for your chiropractic needs. Please fill out this form in as much detail as possible. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please print)

Patient Information:

Name _____ Date _____
First Middle Last

Address _____

City _____ State _____ Zip _____

Social Security # _____ Home Phone (___) _____

Cell Phone (___) _____ Work Phone (___) _____

Do you prefer to receive calls at: Home ☐ Cell ☐ Work ☐ No Preference ☐

E-mail Address _____

Age _____ Date of Birth _____ Sex: Male ☐ Female ☐

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

Patient Employer/School _____ Occupation_____

Employer/School Address _____

Spouse or Parent's Name _____ Employer _____

Whom may we thank for referring you?_____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Insurance Information / Responsible Party:

Name of person responsible for this account:_____

Name of insured _____ Relationship to patient_____

Birthdate _____ Social Security # _____

Address _____ City _____ State _____ Zip_____

Employer _____ Work Phone (___) _____

Name of Insurance Co. _____ ID # _____ Group #_____

Do you have a deductible? Yes ☐ No ☐ How much have you used? _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes ☐ No ☐
If you answered **yes** to this question please provide the front desk with the additional insurance information.

Symptoms:
Have you ever had chiropractic care before? _____

For what problem? _____

1. Major complaint/symptom _____
   When did the problem (pain) begin? _____
   How do you believe the problem began? _____
   What is the quality of the pain? Sharp ☐ Dull ☐ Aching ☐ Burning ☐
   Tingling ☐ Throbbing ☐ Stiffness ☐ Cramping ☐ Swelling ☐ Other ☐
   Where is the pain located (specifically) _____
   What positions or activities aggravate your condition? _____
   _____
   What positions or activities relieve your condition? _____
   _____
   Rate the severity of your pain (1 = mild – 10 = severe) 1 2 3 4 5 6 7 8 9 10
   What treatment(s) have you received for this condition?_____
   Who was the treating doctor _____

2. Second complaint/symptom _____
   When did the problem (pain) begin? _____
   How do you believe the problem (pain) began?_____
   What is the quality of the pain? Sharp ☐ Dull ☐ Aching ☐ Burning ☐
   Tingling ☐ Throbbing ☐ Stiffness ☐ Cramping ☐ Swelling ☐ Other
   Where is the pain located (specifically) _____
   What positions or activities aggravate your condition? _____
   What positions or activities relieve your condition? _____

Rate the severity of your pain (1 = mild – 10 = severe) 1 2 3 4 5 6 7 8 9 10
What treatment(s) have you received for this condition? _____
Who was the treating doctor? _____

3. Third complaint/symptom _____
When did the problem (pain) begin? _____
How do you believe the problem began? _____
What is the quality of the pain? Sharp ☐ Dull ☐ Aching ☐ Burning ☐
Tingling ☐ Throbbing ☐ Stiffness ☐ Cramping ☐ Swelling ☐ Other ☐
Where is the pain located (specifically) _____
What positions or activities aggravate your condition? _____
What positions or activities relieve your condition? _____
Rate the severity of your pain (1 = mild – 10 = severe) 1 2 3 4 5 6 7 8 9 10
What treatment(s) have you received for this condition? _____
Who was the treating doctor? _____

Family History:

Did your mother or father have any of the following conditions:
Please mark **M** for mother, **F** for father, and **B** for both. (*example*: (**M**) Arthritis)

( ) Arthritis
( ) Asthma
( ) Autoimmune Disease
( ) Cancer
( ) Circulatory Problems
( ) Diabetes
( ) Emphysema or Lung Pathology
( ) Heart Disease
( ) High Blood Pressure
( ) Kidney Disease
( ) Mental Illness
( ) Seizures or Convulsions
( ) Stroke
( ) Thyroid Disease
( ) Ulcers or Digestive Disorders

Health History:

Check only those conditions which are applicable.

AIDS/HIV ☐	Cataracts ☐	Hepatitis ☐	Osteoporosis ☐	Stroke ☐
Alcoholism ☐	Chicken Pox ☐	Hernia ☐	Pneumonia ☐	Suicide Attempt ☐
Allergies ☐	Depression ☐	Herniated Disc ☐	Parkinson's disease ☐	Thyroid Disorder ☐
Anemia ☐	Diabetes ☐	Herpes ☐	Pinched Nerve ☐	Tonsillitis ☐
Anorexia ☐	Emphysema ☐	High Cholesterol ☐	Pneumonia ☐	Tuberculosis ☐
Appendicitis ☐	Epilepsy ☐	Kidney Disease ☐	Polio ☐	Tumor/Cancer ☐
Arthritis ☐	Fractures ☐	Lung Disease ☐	Prostate Problems ☐	Typhoid Fever ☐
Asthma ☐	Glaucoma ☐	Measles ☐	Prosthetics ☐	Ulcers ☐
Blood Disorder ☐	Goiter ☐	Migraines ☐	Psychiatric Care ☐	Venereal Disease ☐
Breast Lump ☐	Gout ☐	Mononucleosis ☐	Rheumatoid Arthritis ☐	Yeast Infections ☐
Bulimia ☐	Heart Disease ☐	Multiple Sclerosis ☐	High Blood Pressure ☐	Whooping Cough ☐

Other health problems not listed above: _____

 Patient _____

Name of Primary Care Physician _____

Date of last exam _____

(Women)

Are you pregnant? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐

Date of last menstrual cycle _____ Are you taking birth control pills? Yes ☐ No ☐

List any fractures or dislocations 1. _____ Year _____

(If exact date is unknown – give approximate) 2. _____ Year _____

3. _____ Year _____

List any surgeries have you had 1. _____ Year _____

(If exact date is unknown – give approximate) 2. _____ Year _____

3. _____ Year _____

List any medications/vitamins you are taking 1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Daily Habits:

What level of exercise do you do on a daily basis? None ☐ Mild ☐ Moderate ☐ Heavy ☐

What do your daily work habits include? (sitting, standing, stooped positions, driving, light labor, heavy labor, computer work, repetitive activities, high stress level)

_____

Do you smoke? Yes ☐ No ☐ How much per day? _____

Do you drink alcohol? Yes ☐ No ☐ How much per week? _____

Do you drink caffeinated drinks? Yes ☐ No ☐ How much per day? _____

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 my information including the diagnosis and the records of any treatments and examinations rendered to me or my child during the period of chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor the insurance benefits otherwise payable to me. I understand that my 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 on the behalf of my dependents.

_____ _____

Signature of patient (or parent if patient is a minor) Date