

### PERSONAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  Male  Female

E-mail: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Status:  Married  Single  Widowed  Divorced  Separated

Who should we contact in an emergency? \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**PAYMENT IS EXPECTED AT THE TIME OF VISIT!**  CASH  CHECK  VISA/MC

Are you insured?  YES  NO Primary Insurance: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Date of Birth: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Accident & Injury Chiropractic will prepare any necessary forms and reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Accident & Injury Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of the office, and may be released with a written notification and 15 days notice.

I have received the notice of privacy practices and I have been provided an opportunity to review it.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

Guardian (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CURRENT HEALTH CONCERNS**

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

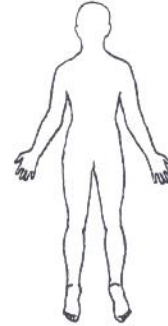
My current health concerns are from:  Auto Accident  Work Injury  Other: \_\_\_\_\_

Major Complaints:

- A. \_\_\_\_\_ D. \_\_\_\_\_
- B. \_\_\_\_\_ E. \_\_\_\_\_
- C. \_\_\_\_\_ F. \_\_\_\_\_

Comments:

PLEASE OUTLINE ON THE DIAGRAM  
THE AREAS OF YOUR DISCOMFORT



**PAST HEALTH HISTORY**

**Please Check & Describe**

Major Surgery/Operations:  Back Surgery  Broken Bones  Neck Surgery  
 Other: \_\_\_\_\_

Major Accident or Falls: \_\_\_\_\_

Hospitalization (Other than above): \_\_\_\_\_

Name of your Medical Doctor: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Previous Chiropractic Care:  None  Yes -  
Doctor's Name: \_\_\_\_\_  
Approximate Date of last visit: \_\_\_\_\_

Thank you for completing this form so that we have all information necessary to process your claims. We look forward to assisting you with your Health Concerns, and at any time please let us know how we may better serve your needs.