# Family Chiropractic Centre

…Where Every Body Belongs™

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to helping you achieve your fullest health potential through chiropractic

## Your Information

Today's date: ______/______/______

Name______________________________________________ Social Sec. # _____-____-______ Birth Date ____ /____ /____
Last First Initial

Address ______________________________________________ City_________________ State _______ Zip ___________

Home Phone #: (_____) _______ - __________ Sex ☐M ☐F Age _____ ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Your Anniversary Date (if married) _____ / _____ / _____ Your **Email**: _____________________@____________ (office use **ONLY**)

**Cell** Phone #: (____)_____-________ Patient employed by __________________________ Occupation ____________________

Business Address _______________________________________________________ Business Phone # (_____)_____-________

Notify in case of emergency _________________ Relation ___________H Phone (____)____-______ W Phone (____)____-_____

Did you receive a courtesy reminder call from our office the day prior to your visit? ☐Yes ☐No

## Primary Insurance (If same as above information write same as above)

Person Responsible for Account __________________________________________ ___________________________________
Last Name First Name Initial Relation to Patient

Date of Birth: ______/______/______ Social Sec. # ____-____-______ Phone #: (____)_____-_______

Address (If different from patient) _________________________________ City ___________________ State _____ Zip _________

Person responsible employed by ____________Occupation __________Name of other dependents under this plan _______________

Business Address ______________________________________________________________ Business Phone (____)____-_____

## Reason for Visit

Have you ever visited a chiropractor? ☐Yes ☐No If yes, when and why? _____________________________________________

Your reason for this visit: __________________________________________________________________________

Describe your current condition (if any) and its location: ____________________________________________________________

When did symptoms begin (date)? ___/___/___ Have you had a similar condition in the past? ☐Yes ☐No

Is condition getting: ☐Worse ☐Better ☐Same ☐Comes & Goes How often do you have this? _________________________

Have you been treated by a medical physician or any other professional for this condition? ☐Yes ☐No If yes, state name of doctor, also when and where? __________________________________________________________________________

Activities or movements difficult or painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting ☐ Standing

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _________________________________________________________________

Is your pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

How Many Children Do You Have? _______
Have they ever visited a chiropractor? ☐Yes ☐No

****Please continue on the back****

# Health History

Please list any medications (including pain killers) you are taking: ______________________________

______________________________________________________________________

Please list & date injuries/surgeries/auto accidents you've had in the past (i.e.: falls, broken bones, traumas, etc.)

______________________________________________________________________

**Women:** Are you pregnant? ☐ Yes ☐ No If so, how far along in pregnancy? ______________________ Breastfeeding ☐ Y ☐ N

# Medical Conditions

Have **you** or any **family** members ever had or currently have any of the following? (Distinguish you versus family member)

☐ Heart Attack/Stroke ☐ Neck Pain ☐ Wrist Pain ☐ Ulcer/Colitis ☐ Arthritis ☐ Severe Frequent Headaches
☐ Congenital Heart Defect ☐ Jaw Pain ☐ Arm Pain ☐ Ringing Ears ☐ Hepatitis ☐ Seizures/Epilepsy
☐ High Blood Pressure ☐ Shoulder Pain ☐ Shingles ☐ Dizziness ☐ High Cholesterol ☐ Psychiatric Issues
☐ Diabetes/Tuberculosis ☐ Low Back Pain ☐ Cancer ☐ Fainting ☐ Kidney Problem ☐ Difficulty Breathing
☐ Freq. Colds/Earaches ☐ Leg Pain ☐ Anemia ☐ Gout ☐ Alcohol/Drug Abuse ☐ HIV(+)/ AIDS/ STD's
☐ Artificial Bones/Joints ☐ Emphysema/Glaucoma ☐ Tingling, where? ______________________________
☐ Numbness, where?______________________________ ☐ Muscle Spasms, where?______________________________

# Personal Habits

Please rate the following with a score of 1 **(low)** to 5 **(high)** regarding their frequency on a weekly basis:

Alcohol ____, Coffee ____, Tobacco ____, Drugs ____, Exercise ____, Sleep ____, Appetite ____, Candy ____, Sugar, ____, Diet Pills ____, Dairy ____, Diet Soda ____, Red Meat ____, Recreational Drugs ____, Margarine ____

How do you rate your stress levels from 1-10 (1 – Lowest, 10 – Highest)? ______________________________

**Considering that our existing patients refer most of our new patients to us, who may we thank for referring you? ______________________________**

# Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Family Chiropractic Centre (FCC) to help determine the appropriate chiropractic care. If there is any change in my medical, insurance, or financial status, I will inform this office immediately. I also understand that all patient related information is kept strictly confidential by FCC and released only by prior authorization of the patient or a legal guardian of the patient

I authorize my insurance company to pay FCC all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize FCC to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance, unless prior arrangements have been mutually agreed upon by both parties.

FCC does not claim to treat, diagnose, or cure any disease, infirmary, or condition presented by the patient to FCC either verbally or in writing.

Signature______________________________________________ Date ______/______/______

****Payment is due in full at the time services are rendered unless prior arrangements have been approved****

**NPI 05/29/05**

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