ALL HEALTH CHIROPRACTIC CENTER

Personal Information

Patient Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____ Employed By_____ Occupation_____

Marital Status M__S__D__W__ Spouse's Name_____ Children **Y** or **N**

Whom can we thank for referring you to our office? _____

Insurance Information

Please check one of the following that best describes your health insurance situation:

Personal Ins.___ Cash___ Worker's Comp___ Auto Insurance___ Medicare___

Primary Insurance

Insurance Company Name _____Phone No. ( )_____ - _____

Subscriber/Insured's Name _____Relationship to Patient _____

Subscriber/Insured's Date of Birth ___/____/_____

Authorization and Assignment

I do hereby authorize payments of medical benefits to be made directly All Health Chiropractic Center, for services rendered to me. I also authorize All Health Chiropractic Center to release any medical information necessary to aid in the processing of my claims.

Authorized Signature _____

All first visit charges are payable when services are rendered.

Method of Payment to be used today? Cash Check Credit Card

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that All Health Chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to All Health Chiropractic Center 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 that 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 to me will be immediately due and payable.

Patient Signature _____ Date _____

Health History

Reason for consulting our office: Intensity Scale

1 low 10 unbearable

1. _____ How long?_____ 1 2 3 4 5 6 7 8 9 10
2. _____ How long?_____ 1 2 3 4 5 6 7 8 9 10
3. _____ How long?_____ 1 2 3 4 5 6 7 8 9 10

Have you seen a chiropractor before? **Y** or **N** If yes, who? _____

Reason for discontinuing care:_____

Is it okay that we talk to your medical doctor to help maximize your healthcare? **Y** or **N**

Current Medications:_____

Do you feel your medication is working? **Y** or **N**

If you could get off your medications would you want to? **Y** or **N**

Please list all surgeries:_____

Were you vaccinated? **Y** or **N** Were you on medications as a child? **Y** or **N**

Do you smoke? **Y** or **N** Do you drink **Y** or **N**?

List your current exercises:_____

Do you eat dairy? **Y** or **N** Do you eat grains? **Y** or **N**

Do you drink coffee? **Y** or **N** How many hours of sleep do you get? _____

Check off any of the following symptoms you have ever had even if you think they're not related to your problem:

__Neck Pain ___ Arm Pain __Shoulder Pain __Hand or Wrist Pain __Mid Back Pain

__Low Back Pain __Foot Ankle Pain __Arthritis __ Jaw Pain __Scoliosis __Fainting __Anxiety

__Numbness __Dizziness __Forgetfulness __Depression __Earaches __Stress __Fatigue __Allergies

__Headaches __Diabetes __Cancer __Excessive Thirst __GERD __Bowel Problems __Liver Problems

__Weight Problems __Gallbladder Problems __Kidney Problems __Incontinence __Chest Pain

__Shortness of Breath __Hypertension __Lung Problems __Stroke __Vision Problems __Dental Problems

__Sore Throat __Sinus Problems

Females Only: Are you pregnant? _____

Family Health Profile – Please mention below any health conditions your family may have

Mother _____ Father_____ Sister_____

Brother _____ Spouse_____ Child_____

Patient Signature: _____ Date:_____