

1

WELCOME to Delta Chiropractic

2

ABOUT YOU		
Today's Date _____ / _____ / _____ File #: _____		
Name: _____		
What You Prefer To Be Called: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birthdate: _____ / _____ / _____ Age: _____ SS#: _____		
Home Address: _____		
City	State	Zip
Home Phone#: _____ Cell# _____		
E-Mail Address: _____		
Referred By: _____		
Employer: _____ How Long? _____		
Employer's Address: _____		
City	State	Zip
Occupation: _____ Work Phone: _____		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Spouse's Name: _____ Spouse's Work Phone: _____		
(or next of kin)		
Medical Physician's Name: _____		

INSURANCE INFO
Co. Name: _____
Address: _____
Phone#: _____
Insured's SS#: _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____
Relationship: _____ Date of Birth: ___/___/___
Insured's Employer: _____
Please Inform front desk of second Insurance source.

REASON FOR VISIT
Have you had previous chiropractic care? _____
What is your major complaint? _____
Other complaints: _____
How did condition develop? _____
Date of onset: _____ Have you had same or similar problems in the past? _____
Is this condition getting worse? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> constant <input type="checkbox"/> comes & goes
How long has it been since you really felt good? _____
What aggravates condition? _____ Does anything offer relief? _____
How would you describe discomfort? <input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> achy <input type="checkbox"/> throbbing
What percent of time does this condition bother you? <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
How would you rate the level of discomfort on a scale of 0-10 (0=no pain 10=extreme pain)? _____
Others who have treated you for this condition: _____

3

4

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood thinners Tranquilizers Insulin Other(s) _____

Have you ever had any of the following diseases/medical condition(s)?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Pain	Y N Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List all previous surgeries/treatments with dates: _____

List any and all accidents with dates: _____

Do you exercise regularly? No Yes / How much? _____ How long? _____

Do you smoke? No Yes / How much? _____ How long? _____

Have you ever . . .

Bought H2O _____ Joined a Health Club _____

For women: Are you taking birth control? Yes No

Are you pregnant? No Yes / How Long? _____ Nursing? Yes No

5

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

S.S.#: _____

D.L.#: _____

Work Phone #: _____

Payment method:

Cash Check Credit Card

CC#(if accepted): _____ / _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

• We invite you to discuss with us any questions regarding 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 rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

• The doctor reserves the right to make any financial arrangements necessary to provide affordable care in the event of a hardship situation.

• I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

• I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date ____/____/____

• I authorize the staff to perform any necessary services needed during diagnosis or treatment on my minor child.

Signature _____ Date ____/____/____