Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

SSN: _____ Sex: □ M □ F Marital Status: □ Single □ Married □ Widowed □ Divorced

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Email: _____ □ Check this box to receive our periodic email newsletter
(CURRENT EMAIL ADDRESS IS IMPORTANT. We may use it to provide you with a user name/password to access certain health information.)

Race: □ White □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Other Pacific Islander

Ethnicity: □ Non-Hispanic □ Hispanic Employment Status: □ Employed □ Part-time Student □ Full-time Student □ Other

Preferred Name: _____

Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Contact in Case of Emergency (Not living in home of patient)

Name: _____ Phone: _____ Relationship to Patient: _____

Is Your Illness or Injury Related to Any of the Following?

□ Employment □ Emergency □ Accident □ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? □ Yes □ No Employer Contact Name: _____

How Were Your Referred to Our Office?

□ By an Attorney □ By a Doctor □ By a Patient □ Internet □ FACEBOOK □ Yellow Pages □ Office Sign □ Other _____

Please print the name of your source: _____

Smoking Status

□ Current Every Day Smoker □ Current Some Day Smoker □ Former Smoker □ Never Smoker

TURN OVER → CONTINUE ON BACK

Describe Your Current Symptoms and How they Began

□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Other: _____ Date Problem Began: _____

How Problem Began: _____

Current complaint pain level (0 = No Pain, 10 = Unbearable): 0 1 2 3 4 5 6 7 8 9 10

How often are your symptoms present? (Occasional) □ 0-25% □ 26-50% □ 51-75% □ 76-100% (Constant)

Are Symptoms: □ Getting Better □ Getting Worse □ Staying the Same

In general would you say your overall health right now is: □ Excellent □ Very Good □ Good □ Fair □ Poor

Check any of the following that describe your condition:

□ achy □ dull □ sharp □ burning □ shooting □ shocking □ throbbing □ numb □ tight □ other _____

What makes it feel better? _____

What makes it feel worse? _____

Have you had recent spinal x-rays, MRI, or CT Scan for your area(s) of complaint? □ No □ Yes Areas:_____ Date:_____

Personal Health History

Please check all of the following that apply to you:

□ Alcohol/Drug Dependence	□ Dizziness/Fainting	□ Urinary Problems	□ Corticosteroid Use
□ Recent Fever	□ Numbness in Groin/Buttocks	□ Abnormal Weight Gain/Loss	□ Taking Birth Control Pills
□ Diabetes	□ Osteoporosis	□ Marked Morning Pain/Stiffness	□ Pregnant, # Weeks ____
□ High Blood Pressure	□ Epilepsy/Seizures	□ Pain at Night	□ Surgeries (Explain Below)
□ High Cholesterol	□ Prostate Problems	□ Pain Unrelieved by Position or Rest	□ Cancer (Explain Below)
□ Stroke (Date) _____	□ Menstrual Problems	□ Visual Disturbances	

List any other diagnosed illnesses or explain any of the above items here:

Please List Any Medications, Supplements, or Vitamins You Are Currently Taking (include frequency and dosage if known)

□ I deny taking any medications.

Please List Any Allergies You Have (be sure to include allergies to medications and/or food)

□ I deny having any allergies.

Family History

□ Cancer □ Diabetes □ High Blood Pressure □ Heart Problems/Stroke □ Rheumatoid Arthritis □ Other: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Haven Chiropractic Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____