

Wellness First Chiropractic – Confidential History and Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Sex _____ Marital Status _____ Date of Birth _____ Age _____ Number of Children _____

SS# _____ Occupation _____ Employer _____

Employer Address _____ Wk Phone _____ Hm Phone _____

Cell Phone _____ E-mail _____ Spouse Date of Birth _____

Spouse Name _____ Spouse SS# _____ Employer _____

Name of nearest relative (not spouse) _____ Phone _____

Who referred you to our office? _____

Is your visit due to an injury? Yes No If yes, please check: Auto Work Other

(If this visit is due to a work or auto injury, please see receptionist for a special injury form)

Briefly describe any current symptoms: _____

List other doctors you use for your health care: _____

Previous Chiropractor(s): _____

List any medications that you take: _____

Note any auto accidents with dates: _____

Please check boxes that describe any symptoms you have had in the last 6 months.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and Needles in hand/arms | <input type="checkbox"/> Ears ringing | Female Only |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins and Needles in feet/legs | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Painful menstruation |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Numb fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numb toes | <input type="checkbox"/> Head heavy | <input type="checkbox"/> Breast problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Cancer | Are you pregnant? |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |

Do you have insurance? Yes No If yes, Company _____

I.D.# _____ Policy Group # _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Wellness First Chiropractic extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Wellness First Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working together towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it to prevent any confusion and disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes an alteration of nerve function and interference to the transmission of mental impulses, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provide who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the
(print name)
above statements.

(signature)

(date)

