

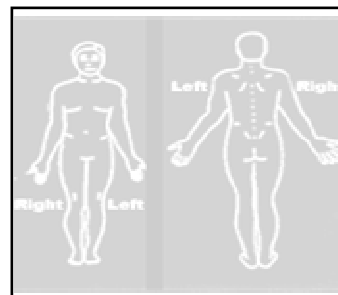
Patient Intake/Update Form

Name: _____ **Date:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone#: _____ **Work#:** _____ **Cellular#:** _____
E-mail: _____ **Social Security#:** _____
Date of Birth: _____ **Age:** _____ **Sex M / F** _____
Occupation: _____ **Employer:** _____
 ___Single ___Married ___Widowed ___Separated ___Divorced
Spouse: _____ **Employer:** _____
Insured's Name: _____ **Insured's DOB:** _____
Method of Payment: ___Cash / Check ___Insurance (please give us a copy of your card) ___Medicare
 ___Auto / Work Injury
How did you hear about our office? Web search engine used: Google Yahoo MSN Other: _____
In case of an Emergency, contact: _____ **Phone:** _____

Please Mark Problem Areas on the Diagram Below:

Please list in order of priority all areas you would like to have examined today.

1. _____
2. _____
3. _____
4. _____



SOCIAL HISTORY

Alcohol: None Social Heavy
Tobacco: Type: _____ Amount: _____
Education: Level or degree attained: _____

Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers Blood Pressure Medicine Insulin Allergy Medicine
Anti-Depressants Other: _____

Past Surgeries: _____ Have you had any of the following problems? Weight Problems
Diabetes Heart Disease Cancer
High Blood Pressure

Any other conditions you feel we should know about—even if unrelated?

TYPES OF CHIROPRACTIC CARE

Chiropractic provides three types of care. The first is initial, acute relief care, which addresses the most recent layer of Spinal & Neurological injury. This care usually reduces and/or eliminates the symptoms. Then begins Corrective Care, Which attempts to correct the years of damage that may have occurred throughout the spine when there were few or no symptoms. And finally, Chiropractic offers a unique and genuine approach to Wellness Care, maintaining the correction and the healthy status you achieved throughout the course of the treatment plan. All of these options will be explained and discussed with you during your report of findings.

- ___ I am interested in acute, relief care only.
 ___ I am interested in finding the source of my problem and correcting it.
 ___ I am not sure at this point.

I understand and agree that health and accident policies are an arrangement 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 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 me will be immediately due and payable.

*I attest that all information given above is correct and accurate, to the best of my knowledge.

Patient / Guardian Signature: _____ **Date:** _____