DR. ANDREA'S

CHIROPRACTIC
&
SPINAL DECOMPRESSION

Welcome

one 1
ABOUT YOU

Today's Date: ________________ File #: ________________

Patient Name: ______________________________________
LAST FIRST MI

What you prefer to be called:______________ Male Female

Birth date: __________ Age: ____ SS#:______________

Mailing Address: ________________________________

____
CITY STATE ZIP

Home Phone #:___________________________________

Work Phone #: ___________________________________

Other Phone(s) #: ________________________________

E-Mail Address: _________________________________

Referred By: ____________________________________

Employer:_____________________ How Long?_________

Employer's Address: ______________________________

____
CITY STATE ZIP

Occupation:_____________________________________

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: __________________________________

Do you have children? Yes No How many? ________

two 2
INSURANCE INFO

Co. Name: ______________________________________

Address: _______________________________________
CITY STATE ZIP

Insureds SS#: ___________________________________

Group # (Plan, Local, or Policy #):____________________

Insureds Name: __________________________________

Relation:_______________ Date of Birth:____________

Insureds Employer: _______________________________

Please inform front desk of 2nd. Insurance source.

three 3
REASON FOR VISIT

The reason for this is a result of work sports auto trauma chronic

(Explain what happened):____

____

Please describe the pain & its location:__________________________________

____

When did condition begin?__________________

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine

If so, please explain: ____

Have you been treated by a Chiropractor before? Yes No

If so, whom? ______________________________ Phone#: ____________________

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IN EVENT OF EMERGENCY

Who should we contact?______________________________

Relation:______________________________

Home Phone #:__________________ Work Phone #: ____________

Who is your Medical Doctor? ____________ Phone #: ______________

five 5

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)__________________

Do you have or ever had any of the following diseases or conditions?

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

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

____

Please list anything that you may be allergic to:______________________

____

List previous surgeries/treatments with dates: ______________________

____

List any past serious accidents with dates:______________________

____

Family Health History: ______________________________

____

Do you: Take Supplements or Vitamins?   Yes   No / Exercise?   Yes   No

Are you on a special diet: Yes   No / Since:____________________

Do you smoke?   No   Yes / How Much? ____________ How Long? ________

Are you wearing: Heel Lifts   Sole lifts   Inner soles   Arch supports

What is the age of your mattress? ________ Is it comfortable?   Yes   No

Are you Pregnant?   No   Yes / How long?__________ Nursing?   Yes   No

six 6

ACCOUNT INFO

Person ultimately responsible for account

Name:____________________________

Relation:____________________________

Billing Address: ____________________

____

CITY   STATE   ZIP

SSN: ____________________________

D.L.#: ____________________________

Work Phone#: ______________________

Payment method: Cash   Check

____

Credit Card - Enter card # above (if accepted)

________ I hereby authorize assignment of my
Initials insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (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 make, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting you account.

I authorize the staff to preform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, 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 to the information I have provide.

Signature____ Date: ________________

Adult Patient   Parent or Guardian   Spouse

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Health Information

GENERAL INFORMATION

First Name: ______________________

Middle Initial:____ Last Name: ______________

Race:
- ❑ American Indian
- ❑ Alaska Native
- ❑ Asian
- ❑ White
- ❑ African American
- ❑ Other Pacific Islander
- ❑ Declined to State

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Declined to State

Preferred Language: ______________________

Email Address: ______________________

OFFICE USE ONLY

Account Number: ______________________

Patient Height: ______________________

Patient Weight: ______________________

Patient BMI: ______________________

Patient Blood Pressure: ______________________

Smoking Status:
- ❑ Current Every Day Smoker
- ❑ Current Some Day Smoker
- ❑ Former Smoker
- ❑ Never Smoker
- ❑ In an effort to quit smoking, I am currently taking: ______________________

Smoking Start Date: ______________ End Date: ______________

Do you have any allergies to medication? ❑ Yes ❑ No

If yes, please indicate the following:

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Are you currently taking any new medication since your last visit? ❑ Yes ❑ No

If yes, please indicate the following:

Medication: ______________________
Route: Oral
Intravenous
Other: ______________________
Frequency: ______________________
Began Use: ______________________
Discontinued Use: ______________________

Medication: ______________________
Route: Oral
Intravenous
Other: ______________________
Frequency: ______________________
Began Use: ______________________
Discontinued Use: ______________________

Medication: ______________________
Route: Oral
Intravenous
Other: ______________________
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