Welcome to Inline Chiropractic

PATIENT INFORMATION

Name:_____ Today's Date:_____
Address:_____City:_____State:_____ Zip:_____
Email:_____Phone#_____Cell Provider:_____
Birthdate_____ Age:_____ Sex: ☐Male ☐Female ☐Other
Status;☐Minor ☐ Single☐ Married ☐ Widowed☐ Separated ☐ Divorced
Employer:_____Occupation:_____ How Long?_____
Employer's Address:_____City:_____State:_____ Zip:_____
Who may we thank for referring you?_____
In case of emergency notify:_____ Phone#_____ Relation:_____

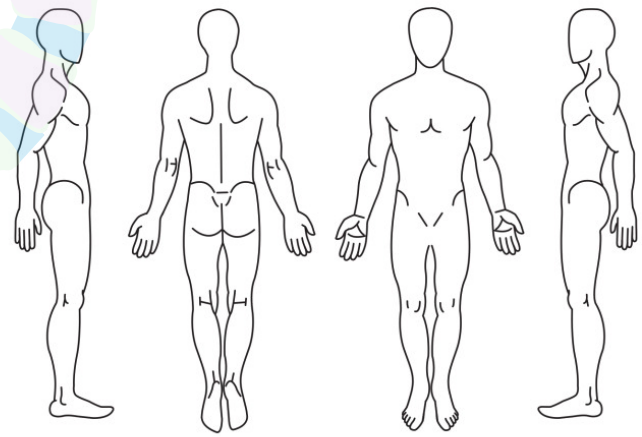
INSURANCE INFORMATION

Primary Insurance
Insured's Name:_____ Relation:_____ Birthdate:_____
Company's Name:_____
Address:_____City:_____State:_____ Zip:_____
Insured's ID#_____ Group #(plan, local or policy)_____
Secondary Insurance
Insured's Name:_____ Relation:_____ Birthdate:_____
Company's Name:_____
Address:_____City:_____State:_____ Zip:_____
Insured's ID#_____ Group #(plan, local or policy)_____

REASON FOR VISIT

Reason for today's visit:_____
Have you been seen by a chiropractor? ☐ Yes ☐ No Clinic or Dr's name:_____
Are you in pain: ☐Yes ☐No Rate you pain on a scale from 1-10:_____
Did injury occur at: ☐ Work ☐ Sport/Play ☐ Auto Accident ☐ Routine/Household activity
When and where did injury/condition occur?_____
Explain what happened:_____
Is your condition getting worse?☐ Yes ☐ No ☐ Constant ☐ Come and goes
Is your condition interfering with your: ☐Work ☐ Sleep or ☐ Daily routine?
If so, how:_____
Has this or something similar happened in the past?
☐Yes ☐ No Explain:_____
_____
_____

Using the adjacent body charts, please circle all affected areas:



HEALTH HISTORY

Are you taking any medications? ☐ Yes ☐ No List of medication you are taking_____

_____

Do you have or ever had:

Y N Heart Attack/ Stroke	**Y N** Heart Surg/pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Detect
Y N Mitral valve Prolapse	**Y N** HIV+/AIDS/ARC	**Y N** Hepatitis	**Y N** Artificial Valves
Y N Shingles	**Y N** High/low blood pressure	**Y N** Ulcers/ Colitis	**Y N** Difficulty Breathing
Y N Alcohol/Drug Abuse	**Y N** Cancer	**Y N** Venereal Disease	**Y N** Psychiatric Problems
Y N Fainting/Seizures	**Y N** Chemotherapy	**Y N** Sinus Problems	**Y N** Lower Back Problems
Y N Frequent Neck Pain	**Y N** Severe/Headaches	**Y N** Glaucoma	**Y N** Rheumatic Fever
Y N Emphysema/Asthma	**Y N** Anemia/ Diabetes	**Y N** Kidney Problems	**Y N** Tuberculosis
Y N Arthritis	**Y N** Artificial Bones/Joints/Implants		

Please List any other serious medical condition(s) not listed above:_____

_____

_____

List any past serious accidents with dates:_____

Please list anything that you may be allergic to:_____

Family health history:_____

Do you take any Supplements or Vitamins? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No _____Hrs per week

Do you Smoke? ☐ Yes ☐ No How much?_____ How long?_____

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting? ☐ Yes ☐ No Since:_____

For Woman: Are you taking birth Control ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If so, how long?_____

OFFICE POLICIES

Due to a largely increased number of missed appointments from various patients, we are going to be stricter on office visit Cancellations/No Show policies starting January 15th, 2021.We are asking patients for a 24-hour notice for cancellations. **Cancellations of less than 12 hours or any No shows will receive an office charge of $20.** If there is an extenuating circumstance, please discuss this with the doctor. We try to be as flexible as we can. Unfortunately, not showing up for your appointment keeps other patients from being seen at these times. We try not to overbook to prevent long waits.

-You are invited 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 is that as a patient, you agree that you will pay for services at the end of each visit unless other arrangements are made. Our office will gladly prepare and file claim forms, but we cannot guarantee the charges will be paid by the insurance company. You agree and understand that if the insurance denies your claim, that you are financially responsible.

--By signing, you authorize the staff to perform any necessary services needed during diagnosis and treatment. You also authorize the provider to release any information required to process insurance claims.

--You understand the above information and guarantee this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes to the information that you provided.

Patient Signature_____ Date_____