WELCOME

We are so happy your here! Please answer the following questions to the best of your ability and we will see you as soon possible

About You

Last Name _____ First Name _____ Middle Initial _____

Nickname_____ ☐ Male ☐ Female Birthdate ___ /___ /____

Age____ Mailing Address _____

City_____ State ____ Zip Code _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Referred by _____ Occupation_____

Employer _____

Maritial Status Minor Single Married Divorced Seperated Widowed

Spouse or Parents Name _____ Children _____

Reason for Visit

You're visit today is a result of: ☐ Work related accident ☐ Auto accident ☐ Sports injury ☐ Trauma ☐ Chronic ☐ Other

Explain what happened: _____

_____

Describe the pain and its location: _____

_____

When did the condition begin ___ /___ /____ Have you had similar conditions in the past _____

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 another physician for this condition? ☐ Yes ☐ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so whom? _____ Phone number: _____

In the Event of an Emergency

Who should we contact? _____ Relation: _____

Phone number _____ Alternative phone number _____

Who is your family physician _____ Phone number _____

HEALTH HISTORY

Your history is important to us and will help us treat you to the best of our ability.

Your History

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxer ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other _____

Y N Heart attack / Stroke
Y N Congenital heart defect
Y N Alcohol / Drug Abuse
Y N HIV / AIDS
Y N Frequent Neck Pain
Y N High / Low Blood Pressure
Y N Severe / Frequent Headaches
Y N Fainting / Seizures / Epilepsy
Y N Diabetes / Tuberculosis
Y N Lower Back Problems

Y N Heart surg. / Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles
Y N Emphysema / Glaucoma
Y N Psychiatric Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones / Joints

Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitus
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Ulcer / Colitis
Y N Asthma
Y N Chemotherapy
Y N Arthritis

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

_____

Please list anything that you may be alergic to: _____

_____

List previous surgeries / treatments with dates: _____

_____

List any past serious accidents with dates: _____

_____

Family health history: _____

_____

Do You

Y N Take Supplements or Vitamins
Y N Exercise
Y N On a special diet
Y N Do you smoke
Y N Heel lifts

Y N Sole Lifts
Y N Inner Soles
Y N Arch Supports
Y N Are you pregnant? For how long? _____
Y N Are you nursing?

OUR POLICIES

Please read and sign below.

Your Account

____ (initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered at this office. I fully understand I am solely responsible for any balance not paid by my insurance company.

- 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 service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform 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 responsibilty to inform this office of any changes to the information I have provided.

Signature: _____ Date ___ / ___ / ___

☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Thank you!
Dr. Beth Harrill