

Do you have tingling or numbness in:

- Shoulders Hips Arms Legs
- Elbows Knees Hands Feet

Are you wearing:

- Heel lifts Sole lifts
- Inner soles Arch supports

Habits:

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you:

- Take vitamins or minerals? Yes No
- Think you may need vitamins? Yes No

Health Insurance

Insured's Name: _____	Employer: _____
Insurance Company: _____	Group #: _____
Address: _____	Policy #: _____

Job Injury Information

Date of injury: _____ Time of injury: _____ Injury reported to employer? Yes No
Accident description: _____
Name of Workman's Compensation Insurance Company: _____
Address: _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: _____

Payment: Cash Check Visa MasterCard Health Insurance Work Comp Auto

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. 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.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

Information taken by: _____ Date: _____
