
# Welcome

## Patient Information

**Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.**

**( Please Print )**

**Name** _____ **Today's Date** _____
**First M.I Last**

**Home Address** _____ **City** _____ **State** _____ **Zip**_____

**Sex:** ☐ **Female** ☐ **Male** **Birthdate** _____ **E-mail** _____

**Home Phone (**_____**)**_____ **Cell Phone (**_____**)**_____ **Work Phone (**_____**)**_____

**Do you prefer to receive calls at:** ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **No Preference**

**Whom may we thank for referring you to us?** _____

**Emergency Contact Name** _____ **Relationship to self** _____

**Emergency Contact Phone Number (**_____**)**_____

## Insurance Information

**Name of Insured** _____ **Relationship to Patient** _____

**Insurance Company** _____ **Member ID Number** _____

**How much is your deductible (if any) _$**_____

**Specialist Copayment (if applicable) _$**_____

# Symptoms

**Reason for visit ☐ Auto Accident ☐ Personal Injury ☐ Work accident ☐ Other _____**

**When did you first notice the symptom?_____**

**Is the condition getting progressively worse? _____ Rate severity of pain from 1 - 10 _____**

**Where specifically is/are the problem(s) located? _____**

**Activities Difficult to perform? ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting**

**☐ Other _____**

**Is the pain: ☐ Constant ☐ Occasional ☐ Frequent ☐ Intermediate**

**Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Burning**

**☐ Other_____**

**Name and phone number of other Doctor(s) who have treated you for this condition:**

_____

**What treatment have you already received for this condition?**

**☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____**

# Health History

**(Women)Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No**

**Taking birth control pills? ☐ Yes ☐ No**

***Check Conditions which are applicable.***

**☐ Aids/HIV ☐ Arthritis ☐ Cancer ☐ Depression ☐ Diabetes ☐ Hernia**

**☐ Herniated Disc ☐ Heart Diseases ☐ High Blood Pressure ☐ High Cholesterol**

**☐ Migraine Headaches ☐ Pacemakers ☐ Psychiatric Care ☐ Stroke ☐ Thyroid Problems**

**☐ Ulcers ☐ Amputations ☐ Other (Please Specify) _____**

**List any surgeries you have had and the dates which they occurred:_____**

_____

**List any medications you are currently taking and the Condition which you are taking them for:**

_____

**Have you ever had any Bone Fractures or Dislocations? ☐ Yes ☐ No**

**If yes please list the date and region of body of the fracture/dislocation:**

_____

**Do you have any Implants or Prosthetic Devices? If so please list.**

_____

**Have you ever been Hospitalized? If so when and for what reason?**

_____

# Certification and Assignment

**To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if i, or my minor child ever have a change in health.**

**I certify that I, and/or my dependent(s), have insurance coverage with _____**
**Name of Insurance Company/Attorney**
**and assign directly to Stutman Chiropractic P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**
**The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or ONE year from the date signed below.**

_____ _____

**Signature of patient or parent/guardian** **Today's Date**