PATIENT HISTORY

Date: _____

Name: _____ Referred By: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birthdate: _____ Age: _____ Marital Status: _____ Number of Children: _____
Occupation: _____ Employer: _____
Spouse's Name: _____ Occupation: _____ Employer: _____
When did you last see a Chiropractor? _____ Dr. _____
When did you last see an Acupuncturist? _____Dr._____
E-mail address: _____ only used to communicate with you, including our newsletter
I am interested in: Chiropractic ___ Acupuncture ___ Nutritional Counseling ___The doctor to choose what's best for me ___

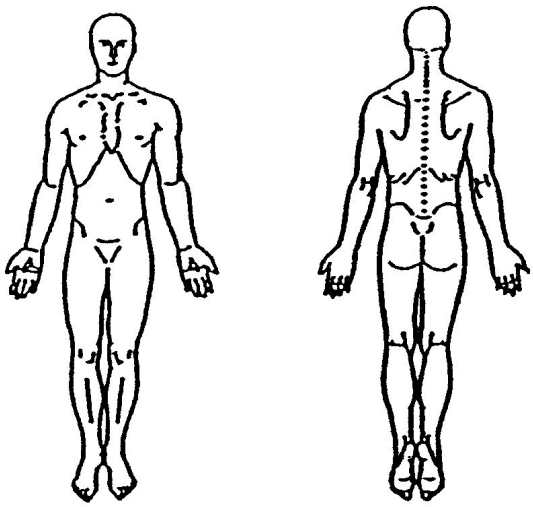
PLEASE FILL IN THE APPROPRIATE SPACES: (All information you give is confidential)

Main reason for seeking care: _____
_____
_____
How long have you had this condition? _____ Date Began: _____
How did condition begin? _____
Have you had this condition before? Yes ( ) No ( ) When _____
Was this injury related to: work accident ( ) auto accident ( ) other ( ): _____
Have you lost work days: Yes ( ) No ( ) How Many? _____Are you working now?_____
Previous injuries and/or auto accidents: _____
_____
Is your problem getting worse? yes _____ no _____ constant _____ comes and goes _____
What makes your problem worse? _____
_____
Is your problem interfering with your: work _____ sleep _____ daily routine _____ other_____
How long has it been since you really felt good? _____
Family History of:
Arthritis ___ Cancer ____ Diabetes ____ Heart Disease ____ Back Problems ____ Scoliosis (Back Curvature) ____
Details: _____
_____
What surgeries have you had? _____
_____
List the drugs you now take (prescription and non-prescription): _____
_____
_____
Name other doctors seen for this condition; what was done, and for how long: (or any other condition): _____
_____
_____

Last Dental check-up: _____ Last Eye Exam: _____ Last physical exam: _____ Date of last period: _____

How often do you use: Alcohol _____ Coffee _____ Tobacco _____

PLEASE COMPLETE THESE DIAGRAMS
Mark the exact location of your pain including the type and frequency of your discomfort. For example, dull, sharp, constant, off and on, when standing, sitting, etc.



_____
_____
_____
_____
_____
_____
_____

Our Financial Policy

Payment is due in full for all services rendered at the time of your visit. We do not accept or file for insurance. We accept cash, personal check, Debit Cards, Visa, MasterCard, Discover and American Express.

We will provide you with a superbill to file with your insurance carrier if you desire. There is a $25 charge per claim should you need any further paperwork and/or phone calls from our office to your insurance carrier. Ultimately, all disputes between you and your carrier are your responsibility.

We do not participate in Medicare or Medicaid. If you are a participant in the Medicare Part B program, you will be required to sign a waiver of liability. The doctor or receptionist will explain our Medicare procedures to you.

If you are requesting treatment as the result of an automobile accident or an on-the-job injury, please let us know before you see the doctor. Payment is due in full for all services rendered at the time of each visit.

All nutritional supplements, books, orthopedic supports or any other items purchased must be paid for in full at time or purchase.

OUR 100% MONEY BACK GUARANTEE: If you find you can't take any of the supplements recommended *for any reason*, you can always bring them back for an exchange or full refund *within 30 days of purchase*.

Massage therapy is available through the clinic. When you schedule a massage, **24 hours advance notice must be given to cancel massage appointments** or you will be charged the full price of the missed appointment.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND THE TERMS OF THIS AGREEMENT

Name of person responsible for payment _____

Patient's Signature _____ Date_____

Guardian's or spouse's signature authorizing care _____ Date_____

Information taken by _____ Date_____