

Patient Information
Total Health Chiropractic

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____ Future appointment reminder by: Text _____ or Voicemail _____

Age _____ Date of Birth _____ Marital Status: M S W D How many children _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Name of Spouse _____ Employer _____

Occupation _____ Work Phone _____

Patient's Nearest Relative _____ Phone _____

Referred by _____ Date of Last Physical Exam _____

Have you ever suffered from:

Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Backaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arm Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Digestive Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lower Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stress	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Any symptoms other than the above _____

Other doctors seen for this condition _____

Have you been treated for any health condition by a physician in the last year Yes No

Describe _____

Primary Healthcare Physician (PCP) _____ Phone _____

Any family history of disease or illness _____

Are you pregnant Yes No. List any medications: _____

Do you smoke Yes No Do you drink alcohol Yes No Do you use drugs Yes No

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment _____

Are you insured Yes No Company _____ Phone _____

I consent to treatment as necessary or desirable to the patient first named above. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made. I further agree if this account be placed in the hands of any attorney or collection agency for collections, I will be responsible for all reasonable collection, attorney and/or court fees. I hereby assign to this office, my rights to receive payments from negligent parties or from insurance companies. I hereby authorize the release of any medical or other information to process claims for payment. I hereby authorize and direct my attorney to pay directly to Total Health Chiropractic such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. Payments should be payable to and mailed to: Total Health Chiropractic

Patient's Signature _____ SS# _____ Date _____

Guardian's Signature _____ SS# _____ Date _____

Attorney's Signature _____ Date _____