Field Chiropractic

Please Print Clearly and fill In completely.

Print Name _____ **Email** _____

Street Address _____ **Phone**_____

City_____**State** _____**Zip**_____ **Date of Birth**_____
Please Check ✓Sex: Male❑ Female❑ Married❑ Single❑ Widowed❑ **SSN:** _____

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them:_____

_____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, the conditions being treated for:

_____

List any past surgeries & dates: _____

List any past accidents/falls & dates:_____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation:_____ Work Duties _____

Spouse's name & health status_____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name_____

Date of last chiropractic visit _____Reason for care_____

Date of last chiropractic x-rays _____How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who? _____

Wellness Commitment

At Field Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%----------20%----------30%----------40%----------50%----------60%----------70%----------80%----------90%--------100%

Where did you hear about our clinic,
or who referred you?_____

FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes❑** **No❑**

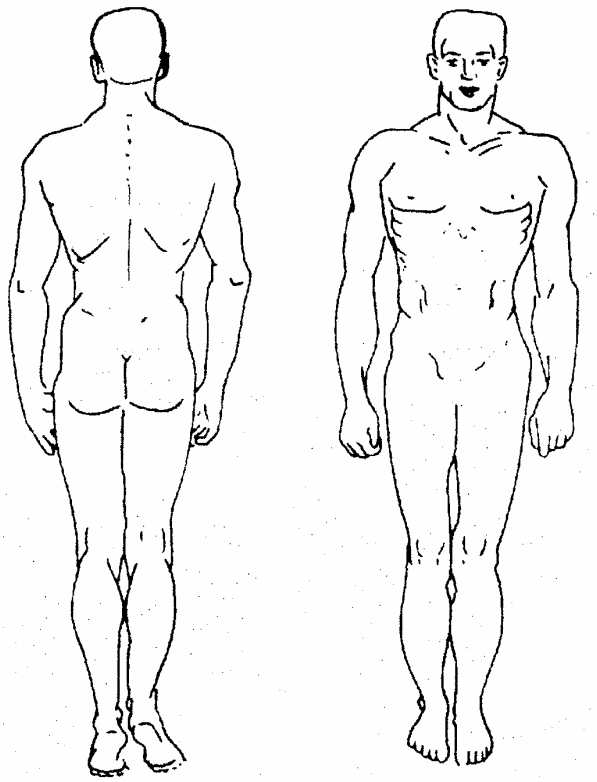
Please Fill in Below

If you have ever had the following, or if you suffer now from the following,

Please Check ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Vision Changes	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Frequent colds	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

Do you have a family history of any of the following:

❑**Cancer** ❑**Heart Disease** ❑**Diabetes**

Please Fill in Below

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINDERALS
Pharmacy Name _____ Pharmacy Phone _____		

If your injuries could be due to an <u>AUTO ACCIDENT</u>, please fill out this page.

Accident Patient History

Date of Accident _____ Time_____
Were you: ❑Driver ❑Passenger ❑Front Seat ❑Back Seat
Were you wearing a Seat Belt? Y_____ N_____ Shoulder Harness ?
Y_____ N_____

Description of Accident

Were you struck: ❑From Behind ❑In Front ❑Right Front ❑Right Middle ❑Right Rear
❑Left Front ❑Left Middle ❑Left Rear
Were you: ❑Moving ❑Stopped ❑Turning Right ❑Turning Left
Approximate speed of automobiles at time of impact_____
Did you see the accident coming? Y_____N_____
Which way were you looking at the time of impact?_____
Upon impact which way was your body thrown? ❑Forward ❑Backward ❑Right ❑Left
Did you hit your head on anything? Y_____N_____ What?_____
Lose consciousness? Y_____N_____ How Long?_____
Amount of damage to vehicle?_____
Type of vehicle?_____
Police report filed? Y_____N_____
Citation issued? Y_____N_____ To whom?_____
When did the pain begin?_____
Since MVA – pain is: ❑Less ❑Same ☐Worse
Transported to hospital? Y_____N_____ Hospital Name:_____
X-rays taken? Y_____N_____
Instructions from ER Doctor_____
Have you seen another Dr. since MVA? Y_____N_____
Dr. Name_____
What treatment did you receive?_____
_____

<u>Please Complete and Sign Below</u>

FINANCIAL INFORMATION:

Who is responsible for this account? _____
What method of payment will you be using? Insurance Cash Check MC/Visa/Discover/AmEx Other
Name of Insurance Company _____ Policy # _____
Insured's Date of Birth _____
Do you have secondary insurance? ( ) Yes ( ) No
Name of Insurance Company _____ Policy # _____

Treatment Authorization

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patients signature (x) _____ Date _____

Consent To Treat a Minor

I (we) being the parents, guardian or custodian of the minor being_____, Age____ , do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature_____ Date_____

Witness _____Date_____