Belmont Chiropractic Clinic

Legal First Name: _____ MI: _____ Last Name: _____

Street: _____Apt: _____

City: _____ State: _____ Zip: _____

Social Security #:_____ Marital Status: S M W D Spouse:_____

Language: _____English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____ French _____ German _____ Russian _____ Other_____

Race: _____ White _____American Indian or Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander _____ Black or African American _____ Decline to Answer _____Other_____

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

Occupation: _____ Employer: _____

DOB: _____ Home Phone: _____ Work Phone:_____

Cell Phone: _____ Fax:_____

Please check your contact preference: _____Hm _____ Wk _____ Cell _____Email _____ Postal Mail

Email hm: _____ Email wk: _____

Emergency Contact:_____ Phone Number: _____

Whom may we thank for referring you to our office? _____

Employer Address: _____

History of Present Illness

Are you seeing anyone else for other problems or health conditions? □ Yes □ No

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ___Yes ___No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

What are you looking for from your care here? Pain Relief____ Corrective Care____ Maintenance Care____

Wellness Care____

Patient History

Past medical history:

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Do you have a history of stroke or hypertension? _____
Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? ___Yes ___No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ___Yes ___No

If yes, describe:_____

Do you have any allergies of any kind? ___Yes ___No

If yes, describe:_____

Social History:
Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? _____ Do you smoke? ____ If so, packs per day: _____
Do you take vitamin supplements? _____ If so, please list:_____
Do you consume caffeine? ____ If so, how much per day:_____
Do you exercise? _____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting _____ sitting _____ bending _____ working at a computer _____

Family History:
Parents:
Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)
Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)
Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? If so, please list:_____
FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	

Other _____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: _____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____