Welcome to Spine & Sport Health

1 About you

Today's Date: ____/____/______ File #:__________

Patient Name: ____________________

Preferred Name: ________________ M ☐ F ☐

Birthdate: _____/_____/_______ Age: __________

Mailing Address: ____________________

CITY STATE ZIP

Home Phone #: ____________________

Work Phone #: ____________________

Cell Phone #: ____________________

Email Address: ____________________

Referred by: ____________________

Employer: ______________ How long?:__________

Employer's Address: ____________________

CITY STATE ZIP

Occupation: ____________________

Status: Minor ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐

Spouse's Name: ____________________

Do you have any family members that are current patients? Yes ☐No ☐Name:______________

2 Insurance Info

PRIMARY HEALTH INSURANCE

Carrier Name: ____________________

Address: ____________________

CITY STATE ZIP

Phone #: ____________________

ID #: ____________________

Group # (Plan, Local, or Policy #) :____________________

Insured's Name: ____________________

Relation: ____________________

Date of Birth: ____/____/_______

AUTO / WORKERS COMP. INSURANCE

Carrier Name: ____________________

Address: ____________________

CITY STATE ZIP

Phone #: ____________________

Claim #: ____________________

D.O.L. (Date of Loss) :_____/______/_______

Adjuster Name: ____________________

Adjuster Phone #: ____________________

Adjuster Fax #: ____________________

3 Account Info

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

Name: ____________________

Relation: ____________________

Billing Address: ____________________

CITY STATE ZIP

SS#: ____________________

Cell #: ____________________

4 In Event of Emergency

Who should we contact?: ____________________

Relation: ____________________

Home Phone #: ____________________

Work Phone #: ____________________

Who is your medical doctor?: ____________________

M.D.'s Phone #: ____________________

Continued on back ❯

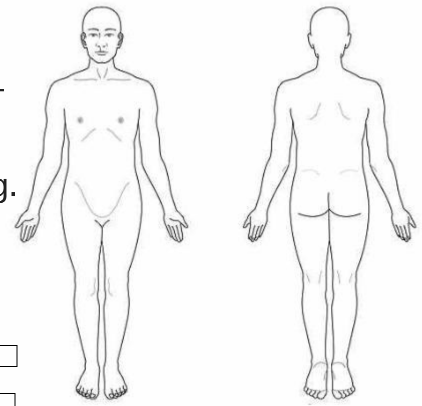
5 Chiropractic Info

Reason for today's visit: Exam ☐ Emergency ☐ Consultation ☐

When did your symptoms appear?: ___________________________________

Is this condition getting worse? Yes ☐ No ☐ Unknown ☐

Mark an **X** on the picture to the right where you have pain, numbness, tingling.



Rate the severity of your pain on a scale of 0 (no pain) to 10 (severe pain).

0 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐
Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other ☐

How often do you feel this pain?: ____

Is it constant or does it come and go?: ____

Does it interfere with your: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities that are painful to perform: Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐

6 Medical History

Are you taking any of the following medications? Nerve Pills ☐ Pain Killers (including asprin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Others _______________

Do you have or ever had any of the following diseases or medical conditions?

Y / N Heart Attack / Stroke	Y / N Jaw problems TMJ/TMD	Y / N Asthma/ Respiratory Prob.
Y / N Heart Surg. / Pacemaker	Y / N Cancer/Tumor	Y / N Diabetes/Hypoglycemia
Y / N Heart Disease/Condition	Y / N Shingles	Y / N Anemia
Y / N Chest Pains/Palpitations	Y / N Hepatitis	Y / N H/L Blood Pressure
Y / N Kidney Problems	Y / N HIV + AIDS/ARC	Y / N Bleeding Problems
Y / N Liver Problems	Y / N Arthritis/Rheumatism	Y / N Back Problems
Y / N Sinus Problems	Y / N Artificial Bones/Joints	Y / N Constipation/Diarrhea
Y / N Stomach Problems/Ulcer	Y / N Fainting/Seizures/Epilepsy	Y / N Heartburn
Y / N Psychiatric Problems	Y / N Frequent Headaches	Y / N Allergic Reactions
Y / N Alcohol/Drug Abuse	Y / N Frequent Neck Pain	Y / N Unexpected weight loss/gain

Please list any other medical condition(s) you have or ever had: ___________________________________

For Women: Are you taking Birth Control? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ Not Sure ☐ How long?: _________________ Are you nursing? Yes ☐ No ☐

- **We invite you to discuss with us any questions regarding our services. The best Chiropractic health services are based on a friendly, mutual understanding between provider and patient.**
- **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Office Manager. If account is not paid within 90 days of the date of service you will be responsible for legal fees, collection agency fees, interest charges and any other expenses required to process insurance claims.**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**
- **I understand that my credit card information will stored safely on file. (More information on Financial Policy Form)**
- **I understand the above information and guarantee this form was completely correct to the best of my knowledge and understand it's my responsibility to inform this office of any changes to the information I have provided.**
- **I would like to receive a copy of the clinic policy and HIPPA form. __________ (initials)**

Signature: __________________________ Date: ____/____/_____