CLICK CHIROPRACTIC- PRACTICE MEMBER INFORMATION

PERSONAL INFORMATION

Date_____ SS#_____

Patient Name_____

Last First M.I.

Address_____

City_____ State_____ Zip_____

Email_____

Sex(Circle) Male Female Age_____ Birthdate_____

Height_____ Weight_____

Marital Status (Circle) Married Single Divorced Widowed Other

Occupation_____

Name of Employer_____

Spouse's Name_____ Occupation_____

Number of Children_____ Names and Ages_____

_____

How did you hear about our office? (Circle) Google Facebook Yelp Website Word of Mouth Phone Book Business Card Other

Who may we thank for referring you?_____

Please list some of your hobbies and interests_____

_____

PHONE NUMBERS

Home Phone (____)_____ Cell (____)_____

Work Phone (____)_____ Other (____)_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Phone(____)_____

FINANCIAL INFORMATION

Who is responsible for this account?_____

Relationship to Patient_____

Method of Payment (Circle) Cash Insurance Medicare Medicaid Other

Insurance Co. #1_____

Policy #_____ Group #_____

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Are you covered by secondary insurance? (Circle) Yes No

Insurance Co. #2_____

Policy #_____ Group #_____

ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Click Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions and disclosure of pertinent information to the above named insurance company(ies).

_____
Signature of Patient, Parent, or Guardian

_____
Please print name of Patient, Parent, or Guardian

_____ _____
Date Relationship to Patient

ACCIDENT INFORMATION

Are you here today because of an Auto or Work accident? (Circle) Yes No

Type of Accident (Circle) Auto Work Other

To whom have you made a report of your accident? (Circle) Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

Claim # _____

Insurance Co._____

PATIENT CONDITION

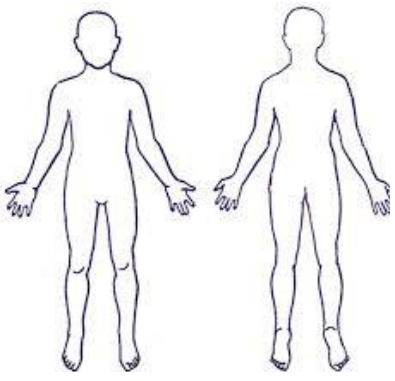
Reason for Visit_____

Last Visit to a Chiropractor (Circle) Less than 3 months ago Never

When?_____ Where?_____

If you have no specific problem but are here for health maintenance, check here_____

Mark an "X" on the picture where you have symptoms or health concerns ⟶



How often does this system occur? (Circle) Constant Daily Weekly Monthly Rarely Only Once

Does it interfere with any of the following activities? (Circle) Work Sleep Recreation Daily Routine

Activities or movements that are difficult to perform (Circle) Sitting Standing Walking Bending Lying Down

--Over--

HEALTH HISTORY

Do you have a family physician? (Circle) Yes No Name_____ Location_____

Have you been seen for any health condition by a doctor other than a chiropractor in the last year? (Circle) Yes No When?_____

Are you pregnant? (Circle) Yes No If so, when is your due date?_____

Please list any known complications during/after your own birth_____

Please list any accidents, injuries, or surgeries you have had	Description	Date
Falls		
Head Injuries		
Motor Vehicle Accidents		
Broken Bones		
Other		

What do you regularly do (or plan to do) to improve your life and health?_____

Please rate your personal or occupational life stress (1=Low, 10=High) 1 2 3 4 5 6 7 8 9 10

Please rate your commitment to your/your family's health (1=Low, 10=High) 1 2 3 4 5 6 7 8 9 10

Please rate yourself in each of the following categories: (Circle)

EXERCISE	DIET	WORK ACTIVITY	REST	HABITS	PREVIOUS CHIROPRACTIC CARE
None	Poor	Sitting	Poor	Smoking	Poor
Moderate	Good	Standing	Good	Alcohol	Good
Daily	Excellent	Heavy Labor	Excellent	Caffeine	Excellent
Heavy		Repetitive Movement		High Stress Levels	

MEDICATIONS

Type	Purpose

VITAMINS/HERBS/MINERALS/SUPPLEMENTS

Type	Purpose

OFFICE POLICIES-By initialing, you agree to the office policies.

_____ARRIVAL-Patients are seen in the order they arrive. Weekly office hours are posted, and all appointments are walk-in during office hours.

_____FINANCIAL ARRANGEMENTS- We expect you to honor the financial arrangements you make with our office. Payment is due when services are rendered.

_____X-RAY- I have been fully informed of the possible dangers to me and unborn fetus that could result from an x-ray examination. To the best of my knowledge, I am **NOT PREGNANT** at this time. I hereby give the doctor permission to x-ray me today, if necessary.

_____PATIENT PRIVACY-I acknowledge that a copy of this office's Statement of Privacy of Rights is available to me upon inquiry, and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

_____FAMILY POLICY-If you have children, your children's spines should be checked for subluxations too.

_____PERTINENT INFORMATION- In the event of any future injury, surgery, sickness or drug usage, it is the responsibility of the patient to update this information with the chiropractor.

Click Chiropractic is a practice designed to keep individuals and families free from nerve interference caused by vertebral subluxations, to allow the body to more fully express its health potential. Chiropractic in this office consists of and is limited to: 1. Analyzing the spine for the presence of vertebral subluxations; 2. Directing specific forces into the spine for the body to use in the correction of vertebral subluxation; 3. Educating and sharing the principles of chiropractic. Chiropractic is not a duplication of, substitution for, or alternative to medical care, and does not include any diagnosis, treatment, cure, or prevention of any medical condition. I have read the above, understand it completely and agree to become a practice member by these terms.

Signature_____ Date _____

Parent/Guardian Signature (if patient is a minor) _____ Date_____