Summit Chiropractic Clinic

"A Better way to stay Healthy!"

Welcome!

Patient Information

Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Birthdate:_____ Age:_____ Gender: M F Marital Status: S M D W Spouse's Name: _____

Contact Information: Phone#:_____ Cell Phone#_____ Email_____

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Primary Language: ☐English ☐Spanish ☐Polish ☐French ☐German ☐Italian ☐Mandarin ☐Cantonese ☐Hindi ☐Japanese ☐Arabic ☐Other_____ ☐Decline to Answer

Emergency Contact Information: Name:_____ Relationship:_____ Phone #: _____

Employers Name:_____ Occupation:_____

Employers Address:_____ City:_____ State:_____ Zip:_____

Which Chiropractor would you like to see? ☐ Dr. Andrew Chalfant ☐ Dr. Ronald Adams ☐ No Pref.

How did you hear about our office? ☐ Yellow Pages ☐Website ☐Road Sign ☐Other ☐Friend/Relative Name:_____

Insurance Information

A copy of your insurance card is also required – Please give the card to the front desk person for a photocopy.

PRIMARY INSURANCE

Insured's Name:_____ Relationship to Applicant: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insured's Birthdate_____Insured's Address, if different:_____

Insurance Company Name:_____ Policy Number:_____

Group Number:_____ Deductible Amount:_____Has deductible been met? ☐ Yes ☐No

SECONDARY INSURANCE

Insured's Name:_____ Relationship to Applicant: ☐ Self ☐ Spouse ☐ Parent ☐Other_____

Insurance Company Name:_____ Policy Number:_____

Group Number:_____ Deductible Amount:_____Has deductible been met? ☐ Yes ☐ No

Please remember your insurance policy is an agreement between you and your insurance company. We will submit your insurance for you but we will hold you responsible for any services provided to you that are not covered or paid by your insurance company.

Authorization and Payment Method

I have completed this form to the best of my knowledge and I give Summit Chiropractic Clinic Authorization to treat me or (my child). I am the person responsible for all fees incurred at Summit Chiropractic.

Signature:_____ Date:_____

☐ Cash/Check/Credit Card ☐Insurance/ Co-payment ☐Auto Insurance ☐ Workmen Comp. Insurance

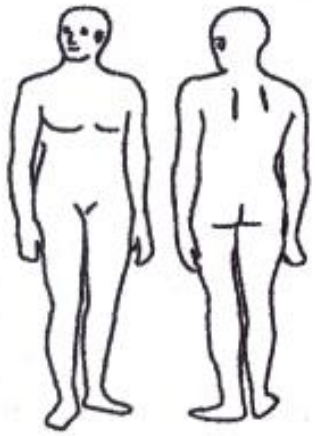
(auto or work related please see receptionist for additional form)

Name:_____

Health Questionnaire

What is your major complaint:_____

When did your symptoms first appear?_____



Mark an X on the picture where you continue to have pain, numbness or tingling.

Cause of Pain? □ Auto Accident □ Work Accident □ Recreation Accident

□ Unknown Cause □ Other:_____

Is condition getting progressively worse? □ Yes □ No □ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of Pain □ Sharp □ Dull □Throbbing □ Numbness □ Stiffness
□ Aching □ Shooting □ Burning □ Tingling □ Cramps
□ Swelling □ Other _____

How often do you have this pain? □ Constant □ Daily □ Weekly □ Monthly □ Come and Go.

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation □ Other:_____

Activities that worsen condition □ Sitting □ Standing □ Walking □ Bending □ Lying down □ Other:_____

Other treatments you have already received for this condition: □ Medication □ Surgery □ Physical Therapy
□ Chiropractic □ Massage □ None

(Female Patients) Are you currently pregnant? □ Yes □ No Signature:_____

Work Activity: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Habits: □ Smoking □ Alcohol □ Coffee/ Caffeine □ High Stress Level

Please list any medications/herbs or vitamins you are currently taking and for what symptom:_____

_____

_____

Please check the conditions which you are currently experiencing below:

□ Headaches	□ Spinal Curvature	□ Ulcers	□ Mid Back pain	□ Shooting Head Pain	□ Loss of Taste	□ Cold Hands
□ Chest pain	□ Numbness in Legs	□ Heart Attacks	□ Sinus Trouble	□ Fainting	□ Low Back Pain	□ Numbness in Hands
□ Constipation	□ High Blood Pressure	□ Loss of Smell	□ Loss of Balance	□ Kidney Problems	□ Hip Pain	□ Hernia
□ Anemia	□ Allergies	□ Neck Pain	□ Menstrual Cramps	□ Stomach Problems	□ Migraines	□ Thyroid Trouble
□ Hay Fever	□ Muscle Spasms	□ Diabetes	□ Nerves	□ Pain in Shoulders	□ Pain in Knees	□ Arthritis
□ Asthma	□ Sleeping Problems	□ Irritability	□ Cold Feet	□ Indigestion	□ Sore Throat	□ Arm Pain

Other Conditions not listed:_____

Additional Information:_____

_____