Walk CHIROPRACTIC & Acupuncture Center

Date:_____

Patient Demographics:

Last Name:_____ First Name:_____ MI:_____

DOB:_____/_____/_____ Age:_____ Gender: M / F **SS#:_____-_____-_____**

Marital Status:_____ #of Children:_____ Employment Status:_____

Address:_____ PO Box #_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Fax:_____

Work Phone:_____ Extension:_____ Professional Title:_____

E-Mail:_____

Please Circle Your Preferred Method of Contact: cell # / home # / work # / e-mail / text / mail

Would you like us to send you an invitation to our Facebook page? Yes / No / I do not have Facebook

Whom or What May We Thank For Your Referral?_____

Employment Information:

Employer Name:_____ Employer Phone:_____

Address:_____ PO Box #_____

Employer City:_____ State:_____ Zip:_____

Emergency Contact:

Contact Name:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Insurance Information

Primary Insurance Company:_____

Primary Insurance Holder: Last Name:_____ First Name_____ MI:____ DOB:_____

Primary Insurance Holder SS#:_____-_____-_____

Patient Relationship to Primary Insurance Holder: Self / Spouse / Child / Other_____

Insurance ID #:_____ **Group #:**_____ **Plan Name:**_____

Secondary Insurance Information

Secondary Insurance Company:_____

Primary Insurance Holder: Last Name:_____ First Name_____ MI:____ DOB:_____

Primary Insurance Holder SS#:_____-_____-_____

Patient Relationship to Primary Insurance Holder: Self / Spouse / Child / Other_____

Insurance ID #:_____ **Group #:**_____ **Plan Name:**_____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Walk Chiropractic & Acupuncture Center for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____

Relationship:_____ Date:_____

Accident Information:

Is condition due to an accident? No / Yes **Date of Accident:**_____

Type of Accident: Auto / Work / Home / Other_____

To whom have you made a report of your accident? Auto Ins. / Employer / Workers Comp. / Other_____

Patient Condition:

Reason(s) for visit:_____

What do you contribute to this condition?_____

When did symptoms first appear?_____ **and is the condition getting:** better / worse / same

How often do you have these symptoms?_____**and are they:** constant / come and go

This condition interferes with: work / sleep / daily routine / recreation / other_____

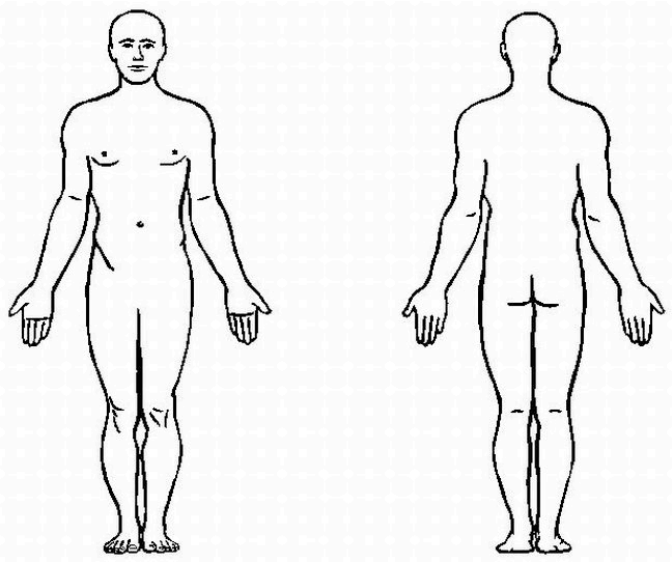
Aggravating or painful activities: sitting / standing / walking / bending / lying down / twisting / other_____

_____

Using the legend below, mark the body diagram where you have any symptoms & rate the intensity of the pain next to each marked location.

Pain Intensity rates from: 0,1,2,3,4,5,6,7,8,9,10 where 0 = no pain and 10 = worst pain imaginable

^^^ Aches
ooo Numbness
*** Pins/Needles
xxx Burning
/// Stabbing
``` Sharp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Walk CHIROPRACTIC & Acupuncture Center

Health History

What treatments have you already tried for your condition? Medications / Surgery / Physical Therapy / Chiropractic / Acupuncture / Massage / Nutrition / None / Other_____

Name of other doctor(s) who have treated you for your condition and dates treated:_____

_____

Please circle all symptoms you had or have and explain below: Where/When/How/What etc…

1) Cold hands
2) Cold feet
3) Constipation
4) Depression
5) Diarrhea
6) Dizziness
7) Fainting
8) Fatigue
9) Headaches
10) Heartburn
11) Hot flashes
12) Irritability
13) Lights bother eyes
14) Loss of balance
15) Loss of smell
16) Loss of taste
17) Menstrual irregularity
18) Menstrual pain
19) Mood Swings
20) Nervousness
21) Numbness in fingers
22) Numbness in toes
23) Pins and needles in arms
24) Pins and needles in legs
25) Ringing in ears
26) Sleeping problems
27) Stomach upset
28) Ulcers
29) Urinary problems
34) Other. List below...

_____

_____

_____

_____

_____

If you take medications, what are you taking and why? (Prescription and non-prescription)

_____

Health History Cont…

Have you had any surgery? (please include all surgeries)

1. Type _____ Date: _____ Doctor_____
2. Type _____ Date: _____ Doctor _____
3. Type _____ Date: _____ Doctor _____

Accidents / Injuries / Illness: (auto, work related, falls, head injuries, childhood illness, etc…)

1. Type _____ Date: _____ Hospitalized [ ] Yes [ ] No
2. Type _____ Date: _____ Hospitalized [ ] Yes [ ] No
3. Type _____ Date: _____ Hospitalized [ ] Yes [ ] No

Have you ever had X-Rays / MRI / CT taken? [ ] Yes [ ] No

(If Yes) Please Explain:_____

Please List Any Allergies Here:_____

Do you wear orthotics or heel lifts? [ ] Yes [ ] No **Do You Smoke?** Yes / No Quantity: _____

Sleeping Questions: **Hours of Sleep**_____ **Position:** Side / Belly / Back

Does pain wake you at night? Yes /No **Quality of Sleep:** Excellent / Good / Fair / Poor

Height:_____ **Weight:**_____ **Are or could you be pregnant?** Yes / No **Due date:**_____

Please Briefly Describe Your Exercise: (What, How Long, How Far, etc…)_____

_____

Please list any supplements you consume and why:

_____

Please rank the following 1 thru 8 where 1 = most consumed and 8 = least consumed:

[ ]Fruits [ ]Veg. [ ]Meat [ ]Water [ ]Dairy [ ]Grains [ ]Sweets [ ]Caffeine

Have you ever had: Chiropractic Care / Acupuncture **and if so when & why?**_____

_____

I want to have (circle all that apply):

1.) pain and symptom relief 2.) the cause of the problem corrected 3.) optimal health and wellness