

Today's date: _____

■ **Who are you?**

Patient's name: _____

Address: _____

City, state & zip: _____

Home phone: _____ Cell: _____

Birth date: _____ Age: _____

E-mail address: _____

■ **Who do we contact in case of an emergency?**

Contact: _____ Phone: _____

Appointment Reminders (circle one): Email SMS/Text Cell Phone Carrier: _____

■ **Occupation?**

Employer: _____ Phone: _____

Whom may we thank for referring you: _____

I will be paying by: Cash Check Credit Card (Visa/Disc/MC/AmEx)

Would you like to receive our e-mail newsletter? Yes No

■ **Do you experience any of these health problems?**

- Headaches Pulled muscles Car accident Sinus pain
- Sleeping problems Leg & hip pain Scoliosis Joint pain
- Emotional stress Stiffness Sadness Worry
- Recent loss Problem focussing

Addictions: _____

Current medications, dose, and why taking: _____

Past surgeries: _____

Do these conditions interrupt...

- Career Sleep pattern Ability to exercise Family life Social life

What methods have you tested?

- Chiropractic Exercise Physical therapy Prescription drugs Nothing

What are your goals for today's session?

Signature of Agreement

I understand and agree that health insurance is an agreement between the carrier and myself. I 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 care, any fees for professional services rendered to me will be immediately due and payable. I acknowledge that if I miss an appointment, I will be charged a \$60 missed visit fee.

Signature: _____ Date: _____

Acknowledgement of HIPPA Privacy Act

My signature acknowledges I have read and understand the HIPPA Act.

Signature: _____ Date: _____

Personal representative name printed: _____

Personal representative signature: _____

Relationship to patient: _____ Date: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Insurance sees will be confidential.