

Welcome to Chiropractic USA!

Our purpose is to educate and adjust as many families as possible towards optimal health through natural CHIROPRACTIC CARE !

CONFIDENTIAL PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Birth Date _____ Email Address _____

Age: _____ Marital Status: **Single** **Married** **Separated** **Widow** **Divorced**

Children: Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

How were you referred to our office? _____
TV Radio Screening Friend Flyer Ad Physician

Employer _____ Occupation _____
Address _____ Telephone _____

Spouse's Name _____ Occupation _____
Employer _____ Telephone _____

Females: Are you pregnant? YES NO NOT SURE

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment : _____

Are you insured? NO Medicare MassHealth BCBS Other _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiropractic USA will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to Chiropractic USA will be credited to my account receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I understand that the fee paid for treatment X-rays is the cost of taking and reading the films. The film itself is the property of this office. Copies of these films (on CD) or any other records can be released with advanced request (usually 24 hrs.) and signed release.

Patient's Signature : _____ Date : _____

Patient Health History

The vast majority of our patients have been involved in dozens of IMPACTS that could cause **VERTEBRAL SUBLUXATION** (spinal misalignment).

The doctor wants to discover **5** of yours.

◆ Whether you felt injured or not, please list all automobile/motorcycle accidents...

| Motor Vehicle Accident Date | Speed | Location of Impact | Any treatment? | Chiropractic care? |
|-----------------------------|-------|----------------------|----------------|--------------------|
| | | Front, Side or Rear? | Yes or No | Yes or No |
| | | Front, Side or Rear? | Yes or No | Yes or No |
| | | Front, Side or Rear? | Yes or No | Yes or No |
| | | Front, Side or Rear? | Yes or No | Yes or No |
| | | Front, Side or Rear? | Yes or No | Yes or No |

◆ Most people have had a slip, strain, or fall at home, work or playing sports, whether it was reported or not. Please list these traumas whether you felt injured or not...

| Circle or list type of trauma | Date | Briefly describe trauma/surgery | Any treatment? | Chiropractic care? |
|--|------|---------------------------------|----------------|--------------------|
| Slip, fall, strain, broken bone, surgery or illness? | | | Yes or No | Yes or No |
| Slip, fall, strain, broken bone, surgery or illness? | | | Yes or No | Yes or No |
| Slip, fall, strain, broken bone, surgery or illness? | | | Yes or No | Yes or No |
| Other: | | | Yes or No | Yes or No |
| Other: | | | Yes or No | Yes or No |

Have you ever fallen while:

1. Learning to crawl or walk? Yes or No
2. Riding a bike, rollerskating/blading, playing...? Yes or No

Does it make sense how **VERTEBRAL SUBLUXATIONS** (spinal misalignments) are caused?

Vertebral subluxation affects your **nervous system**, which affects your **health**.

Please list the names of other chiropractors that have treated you ?

_____ Date _____

_____ Date _____

