Brace Chiropractic and Wellness Center

WELCOME TO OUR OFFICE! ! THANK YOU FOR GIVING US THE PRIVILEGE OF HELPING YOU.

IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

YOUR FULL LEGAL NAME_____ NICK NAME_____

WHO/WHAT REFERRED YOU TO OUR OFFICE?_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

DRIVER LICENSE State and #_____ DATE OF BIRTH_____

SEX_____ MARITAL STATUS_____ SOCIAL SECURITY #_____

E-MAIL ADDRESS_____

PHONES: HOME_____ WORK_____ CELL_____

FAX NUMBER_____

EMERGENCY CONTACT NAME:_____ RELATIONSHIP:_____

PHONE:_____

OCCUPATION_____ EMPLOYER_____ Full or Part Time

EMPLOYER'S ADDRESS_____

WHAT IS YOUR PROBLEM OR COMPLAINT THAT BRINGS YOU HERE?

WHEN DID IT START_____ IS THIS THE FIRST TIME_____ IF NO, WHEN WAS THE FIRST TIME_____

IS THIS PROBLEM DUE TO EITHER A WORK OR CAR ACCIDENT?_____

HOW DID IT START THIS TIME AND THE FIRST TIME (PLEASE DESCRIBE IN DETAIL)_____

WHAT OTHER PROBLEMS AND/OR COMPLAINTS HAVE YOU HAD IN THE PAST_____

DESCRIBE ALL PAST ILLNESSES, SURGERIES, &/OR ACCIDENTS AND THE DATES THEY OCCURED

DO YOU SMOKE?_____ DO YOU DRINK ALCOHOL?_____

HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS?_____

IF YES, WHO AND FOR WHAT CONDITION_____

PRIMARY CARE DOCTOR

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE BEFORE?_____

IF YES, WHY? _____

WHO AND WHERE IS YOUR PREVIOUS CHIROPRACTOR?_____

WHEN WAS YOUR LAST ADJUSTMENT?_____

NAME OF SPOUSE_____

OF CHILDREN: BOYS_____ GIRLS_____

DOES SOMEONE TAKE CARE OF YOU?_____

ARE YOUR PARENTS ALIVE?_____

HAS ANYONE IN YOUR FAMILY DIED FROM ANYTHING OTHER THAN OLD AGE?_____

IF YES, WHO, WHEN AND FROM WHAT?_____

DOES ANYONE ELSE IN YOUR FAMILY SUFFER WITH THE SAME PROBLEMS THAT YOU HAVE?_____

IF YES, WHO, WHAT PROBLEM AND WHAT IS RELATIONSHIP TO YOU?_____

WHAT ILLNESSES OR PHYSICAL AILMENTS ARE IN YOUR FAMILY HISTORY? PLEASE LIST WHOM AND ILLNESS, AGE _____

PLEASE LIST ALL ACTIVITIES THAT YOU CAN NOT DO AS A RESULT OF YOUR CONDITION BE SPECIFIC

DUE TO YOUR ACCIDENT OR ILLNESS, WERE YOU HOSPITALIZED?_____WHAT WERE THE DATES OF HOSPITALIZATION_____

LIST THE VITAMINS AND MEDICATIONS YOU NOW TAKE_____

LIST WHEN AND WHY YOU WERE LAST X-RAYED_____

INSURANCE COMPANY_____

PHONE #_____FAX # _____

INSURANCE ADDRESS_____

IDENTIFICATION #_____POLICY #_____GROUP#_____

IF ANYONE ELSE IS LEGALLY/FINANCIALLY RESPONSIBLE FOR YOU, GIVE THEIR NAME AND ADDRESS ____

FOR WOMEN, ARE YOU PREGNANT?_____IF YES, DUE DATE_____

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian &/or attorney to make payment directly to Brace Chiropractic and Wellness Center for services rendered to me/my family by Brace Chiropractic and Wellness Center . I agree to pay any balance left unpaid. I authorizeBrace Chiropractic and Wellness Center to send bills/claims &/or reports for services rendered directly to my insurance carrier &/or attorney and to release to my insurance carrier &/or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incur with Brace Chiropractic and Wellness Center . If I have financial difficulties/hardships, I shall pay Brace Chiropractic and Wellness Center according to the terms of any agreement that I make with Brace Chiropractic and Wellness Center . This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect Brace Chiropractic and Wellness Center , and to pay Brace Chiropractic and Wellness Center directly from those proceeds. If Brace Chiropractic and Wellness Center has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due Brace Chiropractic and Wellness Center for services rendered by Brace Chiropractic and Wellness Center to &/or for me or my family. I authorize Brace Chiropractic and Wellness Center and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to my/my family's therapy and treatment. Brace Chiropractic and Wellness Center and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize Brace Chiropractic and Wellness Center and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. Brace Chiropractic and Wellness Center is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing