Clegg Chiropractic
Welcome!

Today's Date: _____

About You:

Patient Name: _____ Nickname: _____

LAST FIRST MI

Birthdate: _____ / _____ / _____ Age: _____ SS#: _____ [ ] Male [ ] Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Other Phone: _____

E-mail Address: _____

Emergency Contact Name: _____ Number: _____

Referred by: _____

Employer: _____ How long? _____ Occupation: _____

Status: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Spouse's Name: _____ Do you have kids? [ ] Yes [ ] No How many? _____

Insurance Info:

Insured's Name: _____ Relation: _____ Birthdate: _____

Insured's Employer: _____ 2nd Insurance Source: [ ] Yes [ ] No

Reason for Visit:

The reason for this visit is a result of: [ ] Work [ ] Sports [ ] Auto [ ] Trauma [ ] Chronic [ ] Other

Explain what happened: _____

Please describe the pain and its location: _____

When did the condition begin? _____ / _____ / _____

Is the condition getting worse? [ ] Yes [ ] No [ ] Constant [ ] Comes and goes

Is this condition interfering with your: [ ] Work [ ] Sleep [ ] Daily routine

If so, please explain: _____

Have you had this or similar conditions in the past? [ ] Yes [ ] No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? [ ] Yes [ ] No If so, where? _____

Have you ever been treated by a Chiropractor before? [ ] Yes [ ] No If so whom? _____

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Health History:

List any current medications you are taking: _____

_____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg. / Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/ Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

_____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or manage care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____