CONFIDENTIAL PATIENT INFORMATION

Welcome to our office! Please complete all questions. Thank you.

Name: _____ Address: _____
City/Zip: _____ Home #: _____ Sex: _____ Age: _____
Birth date: _____ Employer: _____ Occupation: _____
Work #: _____ Marital Status: S W D M Spouse's Name: _____
Names and ages of children: _____
E-mail address: _____
How did you hear about our Health Center? _____

Current Health Complaint(s)/ Reasons for Consulting Our Office:
1. _____ 2. _____
3. _____ 4. _____

Have you had similar condition(s) in the past? YES / NO If yes, when?_____

Have you ever seen a chiropractor in the past? YES / NO If yes, please answer the following questions:
When was your last visit? _____ Dr.: _____
Why did you see this chiropractor? _____
Were you helped? YES / NO
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?
_____
Did you follow it? YES / NO If not, why? _____
Why are you changing Chiropractors? _____

What is your health philosophy? (What should you do to be healthy?) _____
_____

How do you want us to handle your problem? Check one.
_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

Why did you come into our office and what are your expectations of us? _____
_____

On a scale of 1 – 10 (10 being the most, and 1 being the least),
_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their maximum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

Consent for Treatment: I, the undersigned, a patient of this office, hereby authorize Health and Wellness Chiropractic Center, P.C. and any of its authorized staff to administer examination and/or treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Consent for Treatment of a Minor: I, the undersigned, hereby authorize Health and Wellness Chiropractic Center, P.C. and any of its authorized staff to administer examination and/or treatment as necessary to my son/daughter.

Payment plans are available upon agreement with the doctor after he determines whether or not to accept your case. Any insurance coverage will be validated at our office. All first visit charges are payable when services are rendered.

Signature of Patient/Guardian:_____ Date : _____