Overlake Chiropractic

Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City, State, Zip:_____ Work Phone: _____

Date of Birth:_____ Patient SS#:_____ Employer:_____

Email Address:_____ Emergency Contact:_____

___ Male ___ Female Phone #:_____

___ Married ___Single ____Other

___ Employed ___ Student ___ Other

Whom may we thank for referring you?_____

If patient is a minor, who is the responsible for this account?_____

Were you involved in an accident? YES / NO _____ Auto _____ Work _____ Other

Health Insurance Information – A copy of your insurance card is required to be on file.

(1) Primary Insurance:_____ ID Number_____ Group_____

(2) Secondary Insurance:_____ ID Number_____ Group_____

Auto accident related, please complete the following

Date of Accident:_____

Your Car insurance Company:_____ Claim/Policy #:_____

Other Driver Insurance Company:_____ Claim/Policy #: _____

Have you Retained an attorney? Y / N Attorney Name:_____ Phone#_____

Work injury related, please complete the following

Employer:_____ Date of Injury:_____ Claim #:_____
(IF CLAIM IS OPEN)

I, the undersigned, certify that I (or my dependent) have insurance with the above and I authorize direct payment to Overlake Chiropractic Clinic for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges whether or not paid for by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims.

Signature:_____ Date: _____

Health History

What treatment have you already received for your condition?

____ Medications ____ Surgery ____ Physical Therapy ____ Chiropractic ____ None ____ Other_____

Name of other doctor(s) who have treated you for your condition:_____

Date of last: Physical Exam:_____ Spinal Adjustment:_____ Spinal X-Ray:_____

✓ Check if applies							
Alcoholism		Frequent Colds		Numbness		Tremors	
Aids/ HIV		Glaucoma		Osteoarthritis		Tuberculosis	
Allergy Shots		Goiter		Osteoporosis		Tumors, Growths	
Anemia		Gout		Pacemaker		Typhoid Fever	
Anorexia/ Bulimia		Hearing Loss		Parkinson's		Ulcers	
Appendicitis		Heart Attack		Pinched Nerve		Whooping Cough	
Arthritis		Hemorrhoids		Pneumonia		Vision Problems	
Asthma		Hepatitis		Polio		Fever (prolonged)	
Bed Wetting		Hernia		Prostate Problem		Mumps	
Bleeding Disorders		Herniated Disc		Prosthesis		TMJ (Jaw)	
Bronchitis		High Blood Pressure		Psychiatric Care		**Women Only:**	
Cancer		High Cholesterol		Rheumatic Fever		Hysterectomy	
Chemical Dependency		Infertility		Rheumatoid Arthritis		Miscarriage	
Chicken Pox		Kidney Disease		Ringing in Ears		Menopause	
Diabetes		Liver Disease		Scarlet Fever		Premenstrual Syndrome	
Difficulty Breathing		Low Back Pain		Sinus Infections		Irregular Menses	
Dizziness		Measles		STD's		Cramps	
Emphysema		Migraines		Stroke		Breast Problems	
Epilepsy		Mononucleosis		Thyroid Problems		Pregnant	
Headaches		Multiple Sclerosis		Tiredness		Due Date:	

Exercise

____ None
____ 1-2 X Week
____ 3-4 X Week
____ 5+ X Week

Work Activity

____ Sitting
____ Standing
____ Light Labor
____ Heavy Labor

Stress Level

____ Low
____ Medium
____ High
Causes:_____

Habits

____ Smoking Packs/Day_____
____ Alcohol Drinks/Week_____
____ Coffee/Soda Cups/Week_____

Type of Exercise:_____

Eating Habits

In the Last 24 hours how many servings of Fruits/Vegetables have you consumed?_____

Is this typical? Y / N How may times per week do you eat fast food?_____

Injuries / Surgeries you have had: **Description:** **Date:**

Falls / Head Injuries _____
Broken Bones / Dislocations_____
Sugeries_____
Work Injuries_____
Auto Accidents_____

Medications:_____
Allergies:_____
Vitamins/ Herbs/ Minerals:_____

The above information is true and correct to the best of my knowledge. I will accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time x-rays, examination and treatments are received, unless other arrangements are made in advance.

Signature:_____ **Date:** _____