FOCUS CHIROPRACTIC & WELLNESS

Guiding people to new heights of health
One patient at a time

Welcome to our office!

Please fill out our New Patient Entrance Form as completely and accurately as possible. If you have any questions, please feel free to ask our qualified Chiropractic Assistant.

It is our pleasure to be of service to you. Our commitment to you is to promise the highest quality of health and well being with Chiropractic care.

Tell Us About You

Name ______________________________

Address ______________________________

City ______________ State ________ Zip ________

Home Phone (_____)______________________

Cell Phone (_____)______________________

Birthday ______________________ Age ______

Gender ☐ Male ☐ Female No. of children ________

Employer ______________________________

Work Address ______________________________

Work Phone (_____)______________________

Type of Work ______________________________

Marital Status ☐ Married ☐ Single ☐ Divorced

☐ Separated ☐ Widowed

Social Security # ______________________________

Email Address ______________________________

Tell Us About Your Family

Spouse's Name ______________________________

Child's Name ______________________ Age ______

Child's Name ______________________ Age ______

Child's Name ______________________ Age ______

Child's Name ______________________ Age ______

Reason For This Visit

Describe the purpose of this visit ______________

____

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall

☐ Chronic Discomfort ☐ Home Injury ☐ Other

Please explain: ______________________

If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No

When did this condition begin? ______________

Has this condition ☐ gotten worse ☐ stayed constant

☐ comes and goes

Does this condition interfere with?

☐ work ☐ sleep ☐ daily routine ☐ other activities

Please explain ______________________

Has this condition occurred before? ☐ Yes ☐ No

Explain ______________________________

Have you seen other doctors for this condition?

☐ Yes ☐ No

Dr.'s Name(s) ______________________

Type of Treatment ______________________

Results ______________________________

Name of Family Physician ______________________

Address ______________________________

Experience With Chiropractic

Who referred you to this office? ______________________________

Have you been seen by a Chiropractor before? ______________________

Reason for those visits? ______________________________

Doctor's Name ______________________________

Approximate date of last visit? ______________________________

Has any *child* in your family seen a Chiropractor? ☐ Yes ☐ No

Past Traumas

Have you ever had? ☐ Motor Vehicle Injury ☐ Sports Injury ☐ Work Injury ☐ Slip and Fall Injury

Please Explain: ______________________________

____

Have you had in other trauma in the past? ______________________________

Have you ever had any surgeries or hospitalizations? If so, please explain ______________________

____

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and other for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ **Relief Care**: Symptomatic relief of pain or discomfort
- ☐ **Corrective Care**: Correcting and relieving the cause of the problem as well as the symptoms.
- ☐ **Wellness Care**: Keeping your body functioning at it's optimal level and highest state of health so you can continue doing the things you want to do as long as you want.
- ☐ I want the Doctor to select the type of care appropriate for my condition

______________________________ ______________

Patient's Signature Date

Medications I Now Take

- ☐ Nerve Pills
- ☐ Pain Killers (including Aspirins)
- ☐ Muscle Relaxers
- ☐ Blood Pressure Medicine
- ☐ Insulin
- ☐ Stimulants
- ☐ Blood Thinners
- ☐ Tranquilizers
- ☐ ____________
- ☐ ____________

Health Habits

	No	Yes
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you drink coffee?	☐	☐

Do you exercise regularly? ☐ No ☐ Moderate ☐ Daily

Do you wear ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch Supports

Health Conditions

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ☐ Severe or Frequent Headaches
- ☐ Sinus Problems
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Pain Between the Shoulders
- ☐ Frequent Neck Pain
- ☐ Numbness or Pain in
- ☐ Arms/Legs/Hands
- ☐ Lower Back Problems
- ☐ Digestive Problems
- ☐ Ulcers/Colitis
- ☐ Heart Attack/Stroke
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Hepatitis
- ☐ Cancer
- ☐ Congenital Heart Detect
- ☐ Heart Surgery/ Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Difficultly Breathing
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcohol/Drug Abuse
- ☐ Venereal Disease
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Shingles
- ☐ Chemotherapy
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Psychiatric Problems

For Women Only:

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking birth control?	☐ Yes	☐ No
Do you experience painful periods?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No
Do you have breast implants?	☐ Yes	☐ No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

______________________________	__________	______________________________	__________
Patient Signature	Date	Guardian or Spouse's Signature	Date

Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp.
☐ Medicare ☐ Personal Health Insurance ☐ Auto Insurance

Ownership of X-ray Films

It is understood and agreed that the payment to the Doctor for X-rays is for examination of X-rays only. The X-rays negatives will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient of this office.

Emergency Contact

Name ______________________________

Relationship ______________________________

Work Phone ______________________________

Home Phone ______________________________

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company______________________________ Policy # ____________________

Address ______________________________ Group #____________________

Phone Number ______________________________

About the Insured Person

Name ______________________________ Insured's Social Security # ____________

Relation ______________________________ Date of Birth ____________________

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Office Fees and Financial Policy

Service	**Fee**
Consultation	**No Charge**
Initial Examination/Nervous System Scans	**$70-$150**
X-rays (3 Views)	**$60**
Progress Examination	**$45**
Adjustments	**$35-$45**

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees; therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to help you.

Important: All client's are responsible for full payment for the first visit (unless other arrangements have been made in advance.)

Today's payment will be made with: (Please circle one) Cash Check Credit Card

Insurance: We will verify all insurance and your benefits per your agreement with your carrier. After verification, the Doctor will give his recommendations and an appropriate plan will be designed for each individual. All patients are responsible for payment of care. If your insurance covers any or all of care, you will be paid directly from your insurance company after your claims are submitted.

Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

Agreement: My signature below signifies my agreement for payment in full on a cash basis if I have not provided Focus Chiropractic & Wellness with all necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

______________________________ (Patient's Name)

______________________________ (Patient's Signature)

Date: ______________________________