



the winchester institute

of chiropractic health & wellness

Welcome • Tell us about yourself!

Patient Name:

Last First Mi

What You Prefer To Be Called:

Male Female

Birthdate: Age: SS#:

Mailing Address & Contact Information

Street:

City: State: Zip:

Home Phone: ()

Work Phone: () Ext:

Cell Phone: ()

E-mail Address:

Referred By:

Employer: How Long?

Employer's Address:

City: State: Zip:

Occupation:

Status: Minor Single Married Divorced
 Separated Widowed

Spouse's Name:

Do you have children? Yes No How Many?

Account Info

Person ultimately responsible for account

Name:

Relation:

Billing Address:

City: State: Zip:

SS #:

Driver's License #:

Work Phone: () Ext:

Payment Method Cash Check Credit Card

Enter Card# Exp. Date: /

Check Box: I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (If offered at this office.)

Initial Here:

New Patient Information

Today's Date: File#:

Insurance Info

Primary Insurance

Co. Name:

Address:

City: State: Zip:

Phone: ()

Insured's ID #:

Group # (Plan, Local or Policy):

Insured's Name:

Relation: Date of Birth: / /

Insured's Employer:

Secondary Insurance

Co. Name:

Address:

City: State: Zip:

Phone: ()

Insured's ID #:

Group # (Plan, Local or Policy):

Insured's Name:

Relation: Date of Birth: / /

Insured's Employer:

In Event Of Emergency

Whom should we contact?

Relation:

Home Phone: ()

Work Phone: () Ext:

Cell Phone: ()

E-mail Address:

Who is your Medical Doctor?

Medical Doctor's Phone: ()

Notes for office use only:

Please continue on back.

Reason For Visit

Reason for today's visit: Emergency New injury Old injury Chronic pain Wellness

Are you in pain: Yes No Rate your pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: Work Sports/Play Auto Accident Routine/Household Activity

When did your condition/accident occur? / / Where did your injury occur?

Please explain what happened:

Is your condition getting worse? Yes No Constant Comes and goes.

Is your condition interfering with your: Work Sleep Daily Routine? If so, how:

Has this or something similar happened in the past? Yes No

Please Explain:

Using the adjacent body charts, please circle all affected area(s).

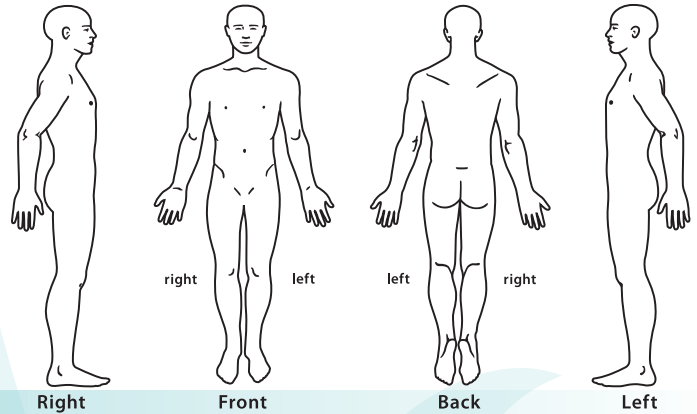
Have you been treated by a Medical Physician for this condition? Yes No

If so, where?_

Have you ever been treated by a Chiropractor? Yes No

Clinic or Dr.'s Name:

Clinic Phone #: ()



Health History

Are you taking any of the following medications? Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants

Blood Thinners Tranquilizers Insulin Other(s):

Do you have or have you had any of the following diseases, medical conditions or procedures? (Please Circle Y or N)

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

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

Please list anything that you may be allergic to:

Family Health History:

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes: Hours per week?

Are you dieting? No Yes: Since / / Do you smoke? No Yes: How much? How long?

Are you wearing? Shoe Lifts Inner Soles Arch Supports

For Woman: Are you taking Birth Control? Yes No Are you Pregnant? No Yes: If so, how many weeks?

Are you Nursing? Yes No

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, interest charges 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 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: / /

Adult Patient Parent or Guardian Spouse

Updates (Office Use Only)

Initials: Date:

Comments:

Initials: Date:

Comments:

Initials: Date:

Comments: