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
SSN:
Birth date: Age:
Referred by:

MAILING ADDRESS & CONTACT INFORMATION

Street:
City:
State: Zip:
Home Phone:
Work Phone: Ext.
Cell Phone:
Email:
Employer:
Employer's Address:
City:
State: Zip:
Occupation:
Status: ☐ Minor ☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Widowed ☐ Partnered
Spouse's Name (if applicable):
Do you have children: ☐ No ☐ Yes: How many?

IN EVENT OF EMERGENCY

Whom should we contact?
Relation:
Home Phone:
Work Phone: Ext.
Cell Phone:
Email address:
Who is your Medical Doctor?
Medical Doctor's Phone:

RESPONSIBLE PARTY

Person Ultimately Responsible for Account

Name:
Relation:
Billing Address:
City:
State: Zip:
SSN:
Home Phone:
Work Phone: Ext.
Cell Phone:
Employer:
Employer's Address:
City:
State: Zip:
Occupation:
Driver's License #:
Payment Method: ☐ Cash ☐ Credit Card
Card #:
Exp. Date: CCV:

INSURANCE

Co. Name:
Address:
City:
State: Zip:
Phone:
Insured's Name:
Date of Birth:
Insured's ID#:
Group# (Plan, Local or Policy):
Relation:
Insured's Employer:

☐ 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:

Please continue to back >

REASON FOR VISIT

Reason for today's visit: ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Interested In Wellness Care (not covered by insurance)

Are you in pain? ☐ No ☐ Yes 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 ☐ Unknown

When and where did your condition/accident occur? _____

Please explain how your symptoms began: _____

_____

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

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

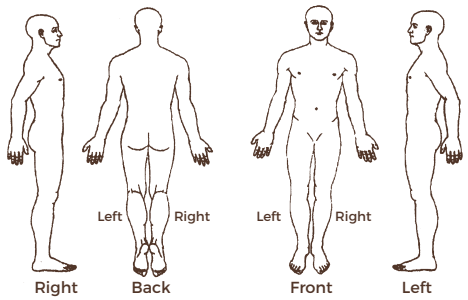
Have you been treated by another Physician for this condition?

☐ No ☐ Yes. If so, when/where? _____

What treatment did you receive? _____

Clinic or Doctor's Name: _____

Clinic Phone: _____



HEALTH HISTORY

Are you taking any of the following medications? ☐ Nerve Pills ☐ Rx/OTC Pain Medication (including Aspirin) ☐ Stimulants ☐ Muscle Relaxers ☐ Blood Thinners ☐ Insulin ☐ Other(s): _____

_____

Do you 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 Heart Surgery/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/ARC
Y N Shingles
Y N Cancer
Y N Frequent Neck Pain
Y N Glaucoma
Y N Anemia
Y N Diabetes

Y N High/Low Blood Pressure
Y N Psychiatric Conditions
Y N Stress/Anxiety
Y N Severe/Frequent Headaches
Y N Kidney Problems
Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy
Y N Auto-Immune Disorders
Y N Sinus Problems

Y N Emphysema/Asthma
Y N Difficulty Breathing
Y N Chemotherapy
Y N Lower Back Problems
Y N Artificial Bones, Joints/Implants
Y N Arthritis
Y N Gut Difficulties
Y N Food Intolerances

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

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

Do you smoke? ☐ No ☐ Yes

Are you wearing: ☐ Arch Supports ☐ Custom Orthodics

Women only:

Are you taking Birth Control? ☐ Yes ☐ No

Are you pregnant? ☐ No ☐ Yes: 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 comfortable, 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 on your account.

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment.

☐ I 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 ☐ Power of Attorney