HEALTHFIRST CHIROPRACTIC

TODAY'S DATE: ____/____/_____

FILE #:_____

WELCOME

PERSONAL INFORMATION

Patient Name:_____ Preferred Name: _____

Birthdate: _____/_____/____ ____Age:_____ ❑ Male ❑ Female SSN:_____

Mailing Address:_____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ Email: _____

Status: ❑ Minor ❑ Married ❑ Divorced ❑ Seperated ❑ Widowed Children: ❑ Yes ❑ No How Many:_____

Spouses Name:_____ Referred By: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____ How long?:_____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Company Name:_____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Id#: _____ Group # (Plan, Local, Policy #): _____

Insured's Name: _____ Relation: _____

Date Of Birth: ____/____/_____ Insured's Employer: _____

Please inform front desk of second insurance source.

REASON FOR VISIT

The reason for this visit is a result of: ❑ Work ❑ Sports ❑ Auto ❑ Trauma ❑ Chronic

Explain what happened:_____

Please describe the pain & its location:: _____

_____

When did condition begin? ____/____/_____ Is it getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes And Goes

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine Explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No Explain: _____

Have you been treated by a medical physician for this condition: ❑ Yes ❑ No

If so, where? _____

Have you even been treated by a chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone #: _____

Are you familiar with the Health Healing System?: ❑ Yes ❑ No What stage are you in? ❑ Relief ❑ Restoration ❑ Revitalization ❑ Praktikos

Have you had a O.N.C.E. Exam? ❑ Yes ❑ No

PICKERINGTON OFFICE • 614-861-1333
1700 CROSS CREEKS BLVD • PICKERINGTON, OH 43147
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642 BROOKSEDGE BLVD • WESTERVILLE, OH 43081
LiveHealthFirst.com

EMERGENCY INFORMATION

Name: _____ Relation: _____

Daytime Phone: _____ Evening Phone: _____

Medical Doctor: _____ Phone: _____

ACCOUNT INFORMATION (PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT)

Name: _____ Relation: _____ Work Phone: _____

Billing Address: _____ City _____ State _____ Zip _____

SSN: _____ D.I. #: _____

Payment Method: ❑ Cash ❑ Check ❑ Credit Card

Credit Card Number: _____ Exp. Date: _____ Initial Here _____

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 comany (if offered at this office.)

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 ever had any of the following conditions? (Please check all that apply.)

❑ Heart Attack ❑ Heart Surgery/Pacemaker ❑ Heart Murmer ❑ Congenital Heart Defect
❑ Mitral Valve Prolapse ❑ Artificial Valves ❑ Alcohol/Drug Abuse ❑ Venereal Disease
❑ Hepatitis ❑ HIV+/AIDS ❑ Shingles ❑ Cancer
❑ Frequent Neck Pain ❑ Emphysema/Glaucoma ❑ Anemia ❑ High/Low Blood Pressure
❑ Psychiatric Problems ❑ Rheumatic Fever ❑ Severe/Frequent Headaches ❑ Kidney Problems
❑ Ulcers/Colitis ❑ Fainting/Seizures/Epilepsy ❑ Sinus Problems ❑ Asthma
❑ Diabetes/Tuberculosis ❑ Difficulty Breathing ❑ Chemotherapy ❑ Lower Back Problems
❑ Artificial Bones/Joints ❑ Arthritis

Please list any other serious medical conditions you have or ever had:: _____

_____

Allergies: _____

Previious surgeries/treatments with dates: _____

Any past serious accidents with dates: _____

Family health history: _____

_____

Do you take supplements/vitamins? ❑ Yes ❑ No Exercise? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No Since: ____/____/_____ Do you smoke? ❑ Yes ❑ No How Much? _____ How Long? _____

Do you wear: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports

What is the age of your mattress?: _____ Is it comfortable? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No How long? _____ 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, and any other expenses incurred in collecting you account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarentee 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

HEALTHFIRST CHIROPRACTIC

TODAY'S DATE: ____/____/_____

FILE #:_____

PAIN CHART

PERSONAL INFORMATION

Name: _____Current Weight: _____Lbs. Current Height: _____Ft. ___ In.

Please Describe You Condition: _____

_____

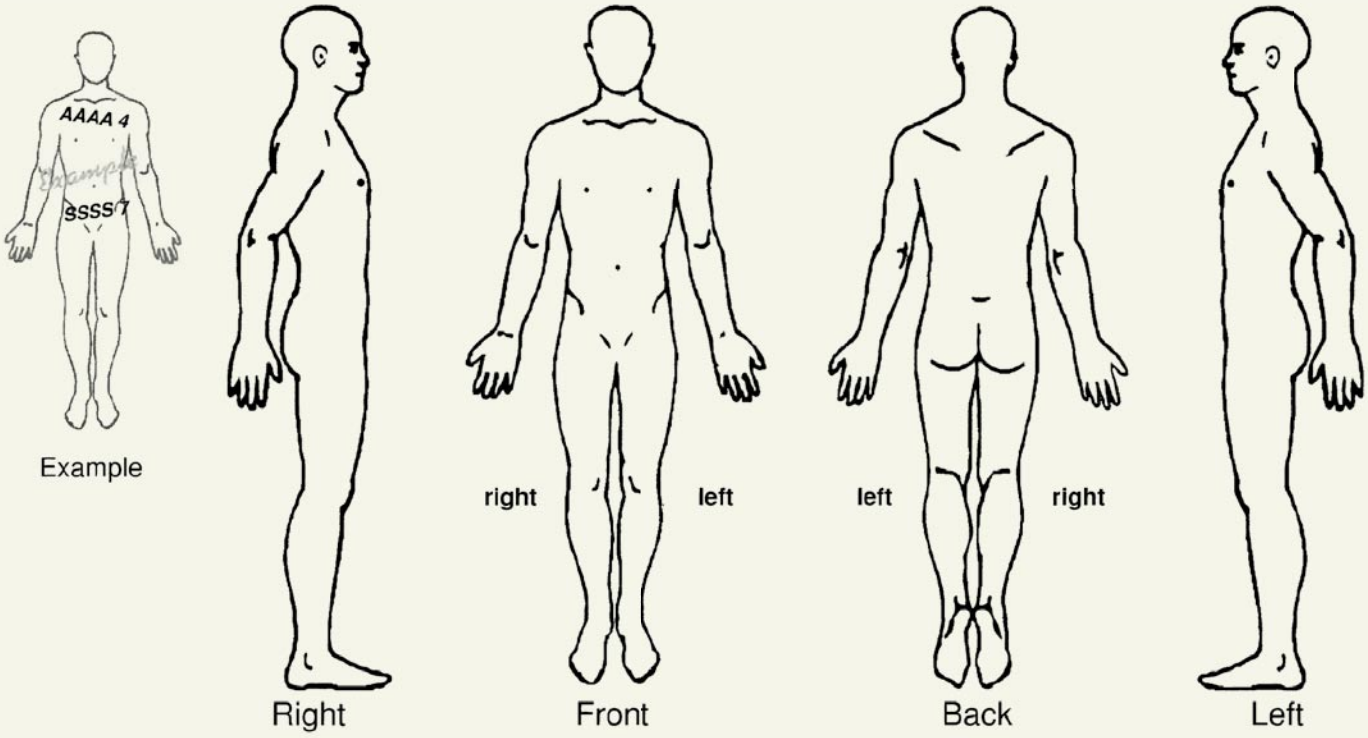
Signature: _____Date: _____

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description	Numbness	Pins & Needles	Burning	Aching	Stabbing
SYMBOL	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol



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