



Healing Touch Chiropractic Center

Please Print Clearly and fill in completely.



Print Name _____ SSN _____ Email _____

Street Address _____ Home Phone _____ Office/Cell Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Please Check ✓ Sex: Male Female Married Single Widowed

Health History:

Give reason for seeking chiropractic care: _____

Describe your health problems, including how long you've had them: _____

What aggravates your condition? _____

Have you had similar problems in the past? _____

Is the condition getting worse? _____ What time of day (if any) is it worse? _____

Is the condition interfering with your work? _____ home life? _____

Are you under the care of any other doctor? Yes No

If Yes, the conditions being treated for: _____

Who is your Primary Physician: _____

Would you like us to send them a courtesy report on your care in our office? _____

List any past surgeries & dates: _____

List any past accidents/falls & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Spouse's name & health status _____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes No If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes No Who? _____

Wellness Commitment

At Healing Touch Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. Which of the following best describes your goals in seeking our care:

1. Symptom relief only _____
2. Correction of the problem along with symptom relief _____
3. Correction of the problem and improvement of overall Health including diet, nutrition, and exercise counseling _____

Where did you hear about our clinic, or who referred you? _____

FEMALES: Please Check One ✓ Is there a possibility of you being pregnant? Yes No

Please Fill in Below

If you have ever had the following, or if you suffer now from the following,

Please Check ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>

Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

**Circle the areas where you have any problems.
Please also describe these problems.**

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Do you have a family history of any of the following:

Cancer Heart Disease Diabetes

Please Fill in Below

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINDERALS
Pharmacy Name _____ Pharmacy Phone _____		

If your injuries could be due to an AUTO ACCIDENT, please fill out this page.

Accident Patient History

Date of Accident _____ Time _____
 Were you: Driver Passenger Front Seat Back Seat
 Were you wearing a Seat Belt? Y _____ N _____ Shoulder Harness ?
 Y _____ N _____

Description of Accident

Were you struck: From Behind In Front Right Front Right Middle Right Rear
 Left Front Left Middle Left Rear
 Were you: Moving Stopped Turning Right Turning Left
 Approximate speed of automobiles at time of impact _____
 Did you see the accident coming? Y _____ N _____
 Which way were you looking at the time of impact? _____
 Upon impact which way was your body thrown? Forward Backward Right Left
 Did you hit your head on anything? Y _____ N _____ What? _____
 Lose consciousness? Y _____ N _____ How Long? _____
 Amount of damage to vehicle? _____
 Type of vehicle? _____
 Police report filed? Y _____ N _____
 Citation issued? Y _____ N _____ To whom? _____
 When did the pain begin? _____
 Since MVA – pain is: Less Same Worse
 Transported to hospital? Y _____ N _____ Hospital Name: _____
 X-rays taken? Y _____ N _____
 Instructions from ER Doctor _____
 Have you seen another Dr. since MVA? Y _____ N _____
 Dr. Name _____
 What treatment did you receive? _____

Please Complete and Sign Below

FINANCIAL INFORMATION:

Who is responsible for this account? _____
Where do you work? _____
Where does your spouse work? _____
What method of payment will you be using? Insurance Cash Check MC/Visa/Discover/AmEx Other
Name of Insurance Company _____ Policy # _____
Insured's Date of Birth _____
Do you have secondary insurance? () Yes () No
Name of Insurance Company _____ Policy # _____

Acceptance of your case, in this office, is conditional upon compliance with the care plan as dictated by the Doctor. In the event you choose to alter from the prescribed treatment plan please be advised that the following will be activated immediately:

1. Most insurance polices terminate payment coverage for non-compliance and therefore all payments must be made in full at the time of each service by the patient and/or responsible party.
2. Your case may be dismissed from care at this clinic.

Patient Signature: _____ Date _____

Treatment Authorization

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed, and any necessary reports to be sent to other physicians. I clearly understand and agree that all services rendered are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I further authorize payment of medical benefits to be paid directly to the Doctor's Office and be credited to my account on receipt. I authorize the use of this signature on all insurance submissions. This authorization is to apply to all occasions of service until it is revoked in writing.

Patients signature (x) _____ Date _____

Consent To Treat a Minor

I (we) being the parents, guardian or custodian of the minor being _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I further authorize payment of medical benefits to be paid directly to the Doctor's Office and be credited to my account on receipt. I authorize the use of this signature on all insurance submissions. This authorization is to apply to all occasions of service until it is revoked in writing.

Parent, Guardian, or Custodian Signature _____ Date _____

Witness _____ Date _____