Quellette Chiropractic and Wellness

Welcome

PATIENT INFORMATION

Patient Name: _____
LAST NAME FIRST NAME M.I.

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Sex: ❑ Male ❑ Female Birthdate: _____ Height: _____ Weight: _____

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Minor SS# _____

Place of Employment: _____

Employer Address: _____

Spouses Name: _____

Whom May We Thank For Referring You? _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

INSURANCE

Primary Insurance
Company Name: _____
Address: _____
Phone #: _____
Insured SS#: _____
Policy #: _____
Group #: _____
Insured's Name: _____
Relationship: _____
DOB: _____

Secondary Insurance
Company Name: _____
Address: _____
Phone #: _____
Insured SS#: _____
Policy #: _____
Group #: _____
Insured's Name: _____
Relationship: _____
DOB: _____

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 for by my insurance company. 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, collections agency fees, and any other expense incurred in collecting your 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 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: _____

PATIENT CONDITION

Describe In Full Your Present Difficulty: _____

_____

Date Of Onset Or Accident: _____

Cause Of Condition Or Accident: _____

Were You Injured At Work?: _____

List Operations and Dates: _____

_____

List Broken Bones and Past Serious Accidents: _____

_____

Have You Had Chiropractic Before? _____ Where? _____

What Makes It Feel Better? _____

What Makes It Feel Worse? _____

Rate the severity of pain on a scale from 1 (Least Pain) to 10 (Severe Pain): _____

Type of Pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning
❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other _____

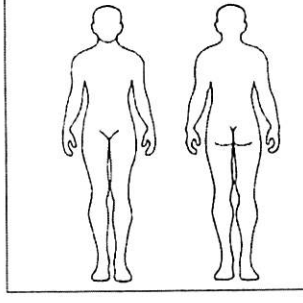
Are you pregnant? ❑ Yes ❑ No Due Date: _____

HEALTH HISTORY

Please indicate if you have had any of the following:

NOW	PAST		NOW	PAST		NOW	PAST	
❑	❑	Aids/HIV	❑	❑	Goiter	❑	❑	Prostate Problem
❑	❑	Alcoholism/Chemical Dependancy	❑	❑	Gout	❑	❑	Prosthesis
			❑	❑	Gall Bladder Trouble	❑	❑	Psychiatric Care
❑	❑	Anemia	❑	❑	Heart Disease	❑	❑	Rheumatoid Arthritis
❑	❑	Anorexia/Bulimia	❑	❑	Hernia	❑	❑	Rheumatic Fever
❑	❑	Arthritis	❑	❑	Herniated Disc	❑	❑	Sinus Trouble
❑	❑	Asthma	❑	❑	High Cholesterol	❑	❑	Skin Condition
❑	❑	Bleeding Disorders	❑	❑	Kidney Disease	❑	❑	Stomach Trouble
❑	❑	Breast Lump	❑	❑	Liver Disease	❑	❑	Stroke
❑	❑	Cancer	❑	❑	Headaches	❑	❑	Thyroid Problems
❑	❑	Constipation	❑	❑	Multiple Sclerosis	❑	❑	Vaginal Infections
❑	❑	Diabetes	❑	❑	Menstrual Trouble			
❑	❑	Dizziness	❑	❑	Osteoporosis			
❑	❑	Emphysema	❑	❑	Pacemaker			
❑	❑	Epilepsy	❑	❑	Parkinson's Disease			
❑	❑	Ear Trouble	❑	❑	Pneumonia			
❑	❑	Eye Trouble	❑	❑	Polio			
❑	❑	Other _____						

Mark an X on the picture where you continue to have pain, numbness or tingling.



EXERCISE: ❑ None ❑ Moderate ❑ Daily ❑ Heavy

WORK ACTIVITY: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

HABITS: ❑ Smoking - Packs/Day_____ ❑ Alcohol - Drinks/Week_____
❑ Coffee/Caffeine Drinks - Cups/Day_____

MEDICATIONS: _____

ALLERGIES: _____

VITAMINS/HERBS/MINERALS: _____