VALLEY CHIROPRACTIC
& SPORTS MEDICINE

Insurance Plan Disclaimer: Please check your insurance benefits prior to your visit. Each policy varies and information we obtain on your behalf is **NOT** a guarantee of coverage. You are responsible to know your benefits and the amount of coverage your policy provides. You are responsible to pay any amount not covered by your insurance policy.

Name:_____

Date of Birth: _____ / _____ / _____ Sex: (circle one) **Male** **Female** **Other:** _____

Cell Phone: (_____)_____-_____ Text: **Y** or **N** Home Phone: (_____)_____-_____

Address:_____

City:_____ State:_____
Zip:_____

Email Address: _____

INSURANCE INFORMATION:

PRIMARY Insurance Co:_____
ID#_____ Relationship to Patient: Self___ Spouse____
Parent_____ Group #_____

Policy Holder/Employee's
Name:_____

Address:_____
Employed by:_____

Employee's Birth Date:_____

SECONDARY Insurance Co:_____
ID#_____ Relationship to Patient: Self___ Spouse____
Parent_____ Group #_____

Policy Holder/Employee's
Name:_____

Address:_____

Employed by:_____ Employee's Birth Date:_____

By signing below, I attest that I have read and understand the above Insurance Plan Disclaimer and that the information I provided is true and accurate. *Co-payments and Deductibles are due at the time services are rendered. You are responsible for any balance that is not paid by your insurance.

A 24-hour notification is required for any cancellation to avoid a $50 missed appointment fee.

Patient Signature:_____
Date:_____

Patient's Name: _____
Date:_____

Have you had Chiropractic Care before?: **Y** or **N** If yes, please provide Dr's name:
_____

Chief Complaint: _____ Onset Date_____

Have you sought treatment for this condition before today?: **Y** or **N**
If Yes, who was the provider and when did you get treatment?
_____

My pain gets better or goes away when I
_____

My pain gets worse when I
_____

My pain is at it's worst:: (circle all that apply) **Morning** **End of the work day** **Night** **Constantly**

Please circle the degree of pain you are *currently* in: (0 = no pain, 10 = severe pain)

0 1 2 3 4 5 6 7 8 9 10

Please circle the degree of pain at its *worst:*

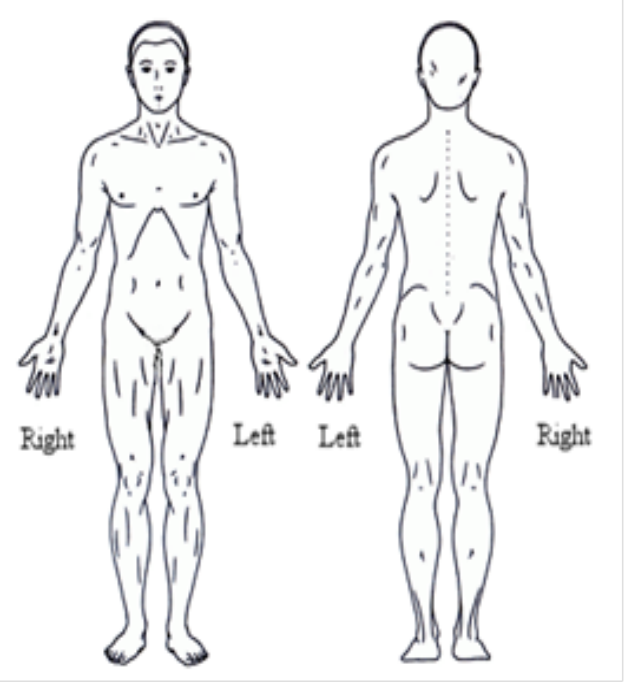
0 1 2 3 4 5 6 7 8 9 10

Please circle the degree of pain at its *best:*

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^



List all medications you are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

Primary Care Physician: _____ Location (Town) _____

HIPPA Acknowledgement:

By signing below, I am acknowledging that I have received a copy of the Privacy Practices Policy for this office.

I understand that my health information may be disclosed to my primary care physician or specialist for health care operations and coordinated care.

If I wish for anyone other than myself to have access to my personal information, I shall list their name and their relationship to me. This will remain in effect until such time as I request a change in writing.

Name(s) of person(s) designated to have access to my personal/healthcare information:

Name:_____
Relationship:_____

Name:_____
Relationship:_____

Patient Signature: _____ Date: _____

Printed Name: _____ Date: _____