Welcome to Eastland Chiropractic & Wellness Center

First Name ____________________ MI ___ Last ___________________ Birthdate ___/___/___ Today's Date___/___/______

Address ____ City ____________________ State _____ Zip ____________

Home # (_____) ________________ Work # (_____) ________________ ext. ____ Driver's License # __________________

Fax # (_____) ________________ Cell # (_____) ________________ E-mail _____________________________________

____Male _____Female # Children_____ ☐ Single ☐ Married ☐ Significant Other ☐ Widowed ☐ Separatede ☐ Divorced

Occupation _________________________ Work Duties ____

Spouse's Name (Parent if patient is under 18) ____ Birthdate ___/___/___

Who may we thank for referring you to our office? ___________________ Method of payment for first visit: *CASH CHECK CC*

Your Health Profile

***FOR PRESENT CONDITIONS MARK "F", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (*Please "Circle" if necessary to be more specific.*)

___Numbness/Tinglling/Pain in (Arms / hands / fingers) R / L Both

___Numbness/Tinglling/Pain in (Buttocks / Thighs / Legs / Toes) R / L Both

___Headaches/Migraines	___Hip Pain R / L	___Neck Stiffness / Pain	___Back Stiffness / Pain
___Fractured Bones	___Arthritis	___Frequent Colds / Flu	___Diabetes
___Swollen Painful Joints	___Convulsions/Epilepsy	___Skin Problems	___Asthma / Emphysema
___Anemia	___Tremors	___Blurred Vision R / L	___Double Vision R / L
___Pain w/Cough / Sneeze	___Chest Pain	___Lung Problems	___Loss of Taste
___Heart Problems	___Stroke	___Gall Bladder Problems	___Digestive Problems
___Prostatic Problems	___Kidney Trouble	___Loss of Smell	___Loss of Balance
___Dizziness / Vertigo	___Buzzing/Ringing in Ears	___Sinus Problems	___Nervousness / Anxiety
___Fatigue	___Depression	___Irritability / Mood Swings	___Tension / Stress
___Colon Trouble	___Sleeping Problems	___Cold Hands	___Stomach Upset
___Cold Feet	___Bed Wetting	___Recurring Infection	___Diarrhea / Constipation / Gas
___Foot Problems	___Shortness of Breath	___Hot Flashes	___Jaw / TMJ Problems
___Cold Sweats	___Light bothers Eyes	___Problems Urinating	___Heartburn / Acid Reflux
___High Blood Pressure	___PMS	___Menopause	___Ulcers
___Other ______________	___Thyroid Problems	___Allergies	___Cancer (Type) ____________

Additional Explanation: ____

____

Have you ever been to a chiropractor before? Y / N When was your last adjustment? ____________________________

Current Health Condition

Chief Complaint: (Why are you here today?): ______________________________

____

____

When did this condition begin?_________ Has it ever occurred before: ☐ Yes ☐ No

Was this due to an accident/Trauma? ☐ Yes ☐ No

If Yes, explain. (for example, fall, auto, sports, etc.)

____

Symptoms: When this problem is at its worst, can you explain in your words how exactly if feels? ____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Does this pain travel or radiate? If so, where? ______________________________

Quality: (Mark all that apply)

☐ Burning ☐ Shooting ☐ Dull / Aching ☐ Localized

☐ Burning ☐ Stabbing ☐ Tingling

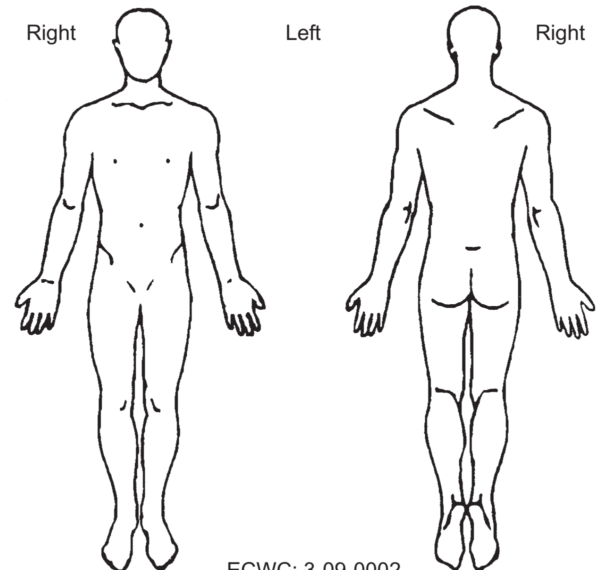
☐ Burning ☐ Other ______________________________

Is there anything that makes this worse? ☐ Yes ☐ No

Explain: ____

Account # ____

Please mark on the diagram below the area of discomfort.



ECWC: 3-09-0002

Patient Name: ______________________________ *Date:* ____________

Timing:

☐ Worse AM ☐ Worse PM ☐ Worse with Activity ☐ Worse Sleeping

☐ Occasional (0-25%) ☐ Intermittent (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)

How often to you find yourself suffering from this problem? ______________________________

How long does the problem last? (All the details of timing) ______________________________

What solutions have you attempted to solve this problem? ______________________________

Please list any effects that this may have on any Recreational Activities: ______________________________

____

Are there any other complaints / conditions that the doctor should address? If so, list and describe: ______________________________

____

____

____

Medications: What medications are you currently taking and for what conditions? ______________________________

____

____

Is there anything else you think the doctor should know about your condition? Yes_____ No_____

____

____

On a scale of 1-10, 10 being the highest, rate your committment to correcting the problem: ______________________________

Insurance Information

Co. Name: ______________________________

Address: ______________________________

____
City State Zip

Phone #: ______________________________

Insured's ID #: ______________________________

Group # (Plan, Local, or Policy#) ______________________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth ____/____/____

Insured's Employer: ______________________________

Please inform front desk of 2nd Insurance source.

Account Information

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

____
City State Zip

SSN: ______________________________

D.L.#: ______________________________

Work Phone #: ______________________________

Payment Method: ☐ CASH ☐ CHECK

______________________________ ____/____

☐ Credit Card - Enter card # above (if accepted)

- 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. If account is not paid within 90 days of the date of the 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 your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand it is my responsibility to inform the office of any changes to the information I have provided.

_____ 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).

Signature ______________________________ Date ___/___/___

☐ Adult Patient ☐ Parent or guardian ☐ Spouse

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