PATIENT INFORMATION

Please answer the following questions as accurately and honestly as possible. This form is very important and will aid your doctor in providing you the best care. If unable to answer a question, please place a check mark next to the question in the left-hand margin.

Today's Date: _____/_____/_____ File #: _____

Last Name: _____ First Name: _____ M.I.: _____

Name you prefer to be called: _____Social Security #: _____

Driver's License # : _____ Birthdate: _____/_____/_____ Age: _____ ❑ Male ❑ Female

Mailing Address: _____City:_____State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone/Pager : _____

E-Mail Address: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____ Number of Children: _____

Referred by: ❑ Friend, Family Member, or Co-Worker (Name, please): _____

❑ SBC Yellow Pages ❑ Valley Yellow Pages ❑ Other: _____

Employer's Name: _____How long employed there? _____

Employer's Address: _____ City _____ State ____Zip _____

Work Phone #: _____ Occupation: _____

Primary Medical Insurance Company Name: _____

Address: _____ City: _____State: ___ Zip: _____

Phone # : _____ Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Insured's ID # : _____

Relation to Insured: _____ Insured's Date of Birth: _____

Insured's Employer: _____

Secondary Medical Insurance CompanyName:_____

Address: _____ City: _____State: ___ Zip: _____

Phone # : _____ Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Insured's ID # : _____

Relation to Insured: _____ Insured's Date of Birth: _____

Insured's Employer: _____

What is your major complaint? _____

Explain what happened: _____

_____

Describe the pain & its location: _____

_____

Please circle the number that best describes your current pain level:

	No Pain		Intermittent moderate pain (marked handicap)
	Minimal pain (annoyance)		Frequent moderate pain
	Constant minimal to intermittent slight pain		Constant moderate pain
	Constant slight pain (some handicap)		Constant moderate to intermittent severe pain
	Constant slight to intermittent moderate pain		Constant severe pain (incapacitated)
	Constant slight to frequent moderate pain		

When did the condition begin? ____/____/____

Is the condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Is the condition interfering with your ❑ Work ❑ Sleep ❑ Daily routine

Please explain: _____

Check any activities that aggravate your condition: ❑ Standing ❑ Walking ❑ Sitting ❑ Lying ❑ Lifting ❑ Bending ❑ Twisting ❑ Coughing ❑ Other: _____

Have you had this condition (or similar ones) in the past? ❑ Yes ❑ No

If yes, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If yes, where? _____

Have you been treated by a Chiropractor before: ❑ Yes ❑ No

If yes, who was the Chiropractor? _____ Phone #: _____

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 have you ever had any of the following diseases conditions, or procedures?

❑ Heart attack / Stroke	❑ Heart surgery / pacemaker	❑ Heart murmur
❑ Congenital heart defect	❑ Mitral valve prolapse	❑ Artificial valves
❑ Alcohol or drug abuse	❑ Sexually transmitted disease	❑ Hepatitis
❑ HIV / AIDS	❑ Shingles	❑ Cancer
❑ Frequent neck pain	❑ Emphysema	❑ Anemia
❑ High / Low blood pressure	❑ Psychiatric problems	❑ Rheumatic fever
❑ Severe / frequent headaches	❑ Kidney problems	❑ Ulcers / colitis
❑ Fainting / seizures / epilepsy	❑ Sinus problems	❑ Asthma
❑ Diabetes	❑ Tuberculosis	❑ Chemotherapy
❑ Lower back problems	❑ Bone or joint replacement	❑ Arthritis
❑ Fibromyalgia	❑ Lupus	❑ Glaucoma

List any other serious medical conditions you have or have had: _____

_____

List anything that you think you are allergic to: _____

List previous surgeries / treatments with dates: _____

_____

List any past serious accidents with dates: _____

_____

Who is your Medical Doctor? _____ Phone #: _____

Do you take supplements or vitamins? ❑ Yes ❑ No Do you exercise? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No If yes, describe _____ How long? _____

Do you smoke ❑ Yes ❑ No If yes, how much? _____ For how long? _____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If yes, how long? _____ Nursing ❑ Yes ❑ No

Family History (Please mark any items than any family member has suffered from)

❑ Tuberculosis ❑ Kidney disease ❑ Spinal disorder ❑ Mental illness ❑ Epilepsy

❑ Diabetes ❑ Gout ❑ Allergies ❑ Arthritis ❑ Cancer

❑ Hypertension ❑ Migraines ❑ Heart attack ❑ Other: _____

In the event of an emergency, whom should we contact? _____

Relation: _____ Home phone: _____ Work phone: _____

Person ultimately responsible for your account:

Name: _____ Relation: _____

Billing address: _____ City: _____ State: ____ Zip: _____

Home phone #: _____ Work phone #: _____

SSN: _____-_____-_____ Driver's License #: _____ State: _____

Payment method: ❑ Cash ❑ Check ❑ Credit Card _____

Credit Card number & exp date

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services

Initials rendered (if offered at this office).

- We invite you to discuss with us any questions you may have 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 the account is not paid within ninety days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and/or any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services for diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee that this form was completed correctly, to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

❑ Adult patient ❑ Parent or guardian ❑ Spouse

There will be a $25.00 fee assessed for each missed half-hour appointment not cancelled at least three hours prior to the appointment time. The fee for a missed hour-long massage appointment will be $45.00 This fee **<u>may</u>** be waived if the cause of the missed appointment is deemed by Downtown Wellness to be a bona fide emergency.

If the fee for the missed appointment is assessed, it will be charged to you, the patient, and NOT to your insurance company.

The fee for a missed appointment must be paid before we can schedule another massage appointment for you.