Chiropractic & Acupuncture

Patient Information

Thank you for choosing Chiropractic & Acupuncture for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: _____ Social Security #: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ❑ Female ❑ Male Birthdate: _____ E-mail: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (_____)_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of employer: _____ Work Phone: (_____)_____

Insurance Information

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security #: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co.: _____ Phone: (_____)_____ Group #: _____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have additional insurance? ❑ Yes ❑ No **If Yes, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#:: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co.: _____ Phone: (_____)_____ Group #: _____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Symptoms

Reason for visit: _____ When did you first notice the symptoms? _____

Is the condition getting progressively worse? Same Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

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

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 10

Is the pain constant or does it come and go? come and go

What treatment have you received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Health History *Check only those conditions which are applicable:*

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostrate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other _____
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	_____
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke	_____

Dates of last exams: _____

(Woman) Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking Birth Control Pills? ❑Yes ❑No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____ Nutritional supplements (if any)? _____

Do you smoke? ❑ Yes ❑ No How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Thomas T. Mang, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I fuly understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Thomas T. Mang, D.C. may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient