

PATIENT INTRODUCTION CARD

(Please Print)

Name _____ Date _____ Case No. _____
(last) (first) (middle)

Address _____ Phone _____

City _____ State _____ Zip _____

Married _____ Single _____ Number of Children _____
Age Ht. Wt. Date of Birth Sex

Occupation or Profession _____

Employed by _____ Business Phone _____

Name of Head of Family _____

Employed by _____ Business Phone _____

Referred by _____

Have you had chiropractic care before? _____ Where ? _____

Do you have health insurance? _____ What company? _____

Social Security No. _____ Who is responsible for account? _____

(name) (address)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the Pecatonica Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Pecatonica Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further understand that any unpaid balance of 60 days or more will be charged 1.5% interest on the unpaid balance each month. In the event that I fail to pay the amounts when due, I understand that I will be in default of our agreement.
DELINQUENCY AND DEFAULT; I AGREE TO PAY THE COSTS INCURRED TO COLLECT THIS BILL IN THE EVENT OF MY DEFAULT IN PAYMENT, INCLUDING YOUR REASONABLE ATTORNEY'S FEES.

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL
MEDICAL RECORDS AND/OR INFORMATION**

I authorize Pecatonica Chiropractic Center to release any medical information or X-rays as needed to process claims for services rendered.

I understand that this release is revocable at any time prior to the release of this information.

ASSIGNMENT OF PAYMENT

My attorney and/or insurance company are hereby requested and authorized to pay direct to Pecatonica Chiropractic Center any monies due on account, the same to be deducted from any settlement made on our behalf.

Further, I agree to pay Pecatonica Chiropractic Center the difference, if any between the total amount of charges and the amount paid by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay Pecatonica Chiropractic Center the full amount of charges, should my condition be such that it is not covered by my policy or **if for any reason** the insurance company refuses to pay my claim.

Dated at 427 Main Street, Pecatonica, IL 61063 this _____ day of _____, 20____

Witness:

Signature of Patient

Patient Name: _____ #: _____ Date: _____

Symptoms and Ill Health (Present State of Ill Health)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Whiplash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other: _____ | | | |

Family History

Father's Side

- Heart Disease
- Arthritis
- Cancer
- Diabetes
- Other: _____

Mother's Side

- Heart Disease
- Arthritis
- Cancer
- Diabetes
- Other: _____

After reading and filling out this history, your signature validates all of the information you have given us is accurate and reflects you current health status. Please sign below:

Patient/Legal Guardian Signature: _____ Date: _____

FOR DOCTORS USE ONLY

Doctor's Notes: _____

Patient Name: _____ #: _____ Date: _____



PATIENT HISTORY

Loss of Wellness (Birth - Age 5)

Birth Process	Yes	No	Comments
Was the delivery long?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was the delivery difficult?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Forceps?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Caesarean?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breach/cephalic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Home birth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospital birth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother given drugs in delivery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was labor induced?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Growth and Development

Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you breast fed?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Childhood sicknesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you fall while learning to walk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chair pulled out while sat down?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you fall down stairs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you yanked by your arm?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have other traumas?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Loss of Whole Body Health (Age 5-present)

Were you taught proper body movement and care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Did/do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Did/do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diet (Do you eat healthy foods?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Have you ever been in accidents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Have you had surgery & organs removed/replaced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Drugs? (Prescriptive or non-prescriptive)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Teeth problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eye problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Exercise regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Sleeping habits (nightmares?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Did/do you have occupational stress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Physical stress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Mental stress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hobbies/sports injuries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other traumas or problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Have you ever been under drug & medical care? Yes No _____

Are you currently taking medication? Yes No How long? _____

List medication(s): _____

Have you had surgery? Yes No If so, when? _____

For what? _____

What side effects, if any, did you experience from the drugs and surgery? _____

Previous x-rays taken? Yes No If so, when? _____ Where? _____

Are you pregnant? Yes No If so, date due? _____

