

NEW CLIENT INFORMATION

1

CLIENT INFORMATION

Date: _____

Name: _____

Address: _____

City _____ State _____ Zip _____

Sex: M F Age: _____ Birthdate: _____

Single Married Cohabiting Widowed Separated Divorced

Occupation: _____

Employer: _____

Employer Address: _____

Spouse's Name: _____

Whom may we thank for referring you to our office? _____

2

PHONE NUMBERS

Home: _____

Work: _____

Cell: _____

Email Address: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Home No. _____

Cell No. _____

3

CLIENT CONDITION

Reason for your visit: _____

When did your symptoms first appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain or symptoms.

Rate the severity of your pain on a scale from 1(no pain) to 10(severe pain) _____

Describe your pain: sharp dull throbbing numbness aching

shooting burning tingling cramping

stiffness swelling other _____

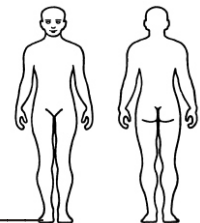
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your work sleep daily activities recreation

Activities or movements that are painful to perform include sitting standing walking

bending lying down other _____



4

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Client: _____

Insurance Co.: _____

Subscriber ID: _____

Group No.: _____

Is the client covered by additional insurance? No Yes _____

Subscriber Birthdate _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to HealthChoice Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

5

ACCIDENT INFORMATION

Is condition due to an accident? Y N

Type of accident: Auto Work Other

To whom have you made a report of your accident? Auto Insurance Employer

Worker's Comp Other

Have you contacted an attorney? Y N

Attorney's Name: _____

CHOICE CHIROPRACTIC GOAL SHEET

1. Why have you chosen Choice Chiropractic? _____

2. Have you ever seen a Chiropractor? When was your last adjustment? _____

3. What are your short term Health goals? _____

4. What are your long-term Health goals? _____

5. What is your primary concern about your health? _____

6. Would you be interested in PREVENTATIVE CARE? Yes No

7. Are you seeking care for just you or your entire family? Me Family

8. How will you be handling your portion of the bill? Cash Check Charge

Signature

Date