MOMENTUM CHIROPRACTIC - PRACTICE MEMBER INFORMATION

1 PERSONAL INFORMATION

Date_____ SS#_____

Patient Name_____
Last Name First Name M.I.

Address _____

City_____ State_____ Zip_____

Email_____

Sex(circle) Male Female Age_____ Birthdate_____

Height _____ Weight_____

Marital Status (circle) Married Single Divorced Widowed Other

Occupation_____

Name of Employer_____

Spouse's Name_____Occupation _____

Number of Children _____ Names and Ages_____

_____

How did you hear about our office? (circle) Existing PatientEmployer

Internet Another ProviderInsurance Co. Business Card Other

Who may we thank for referring you?_____

Please list some of your hobbies and interests_____

_____

2 FINANCIAL INFORMATION

Who is responsible for this account?_____

Relationship to Patient_____

Method of Payment (circle) Cash Insurance Medicare Medicaid Other

Insurance Co. #1_____

Policy #_____ Group #_____

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Are you covered by secondary insurance? (circle) Yes No

Insurance Co.#2_____

Policy #_____ Group #_____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with _____

_____ and assign directly to Momentum 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 insurance. I authorize the use of my signature on all insurance submissions and disclosure of pertinent information to the above named insurance company(ies).

_____
Signature of Patient, Parent, or Guardian

_____
Please print name of Patient, Parent, or Guardian

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home Phone (____)_____ Cell Phone (____)_____

Work Phone (____)_____ Other _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship_____ Phone (____)_____

4 ACCIDENT INFORMATION

Are you here today because of an accident? (circle) Yes No

Type of Accident (circle) Auto Work Other

To whom have you made a report of your accident? (circle)

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable)_____

Claim #_____ Insurance Co._____

5 PATIENT CONDITION

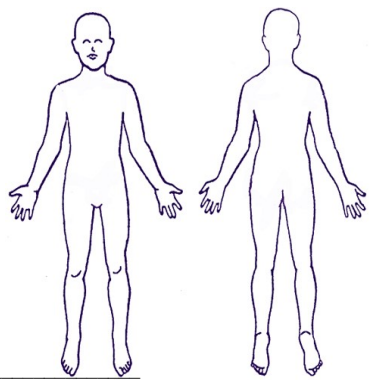
Reason for Visit_____ Date it Started_____

Last Visit to a Chiropractor (circle) Less than 3 months ago 3 months ago or more Never

When?_____ Where?_____

If you have no specific problem but are here for health maintenance, check here _____

Mark an "X" on the picture where you have symptoms or health concerns →



Please Rate your Pain or Discomfort (0= No Pain → 10 = Worst Pain) 0 1 2 3 4 5 6 7 8 9 10

How often does this symptom occur? (circle) Constant Daily Weekly Monthly Rarely Only Once

Activities or movements that are difficult to perform (circle) Sitting Standing Walking Driving Other:_____

-- O V E R --

6 HEALTH HISTORY

Do you have a family physician? (circle) Yes No Name_____ Location_____

Have you been seen for any other health condition by a doctor other than a chiropractor in the last year? (circle) Yes No When?_____

Are you pregnant? (circle) Yes No If so, when is your due date? _____

Please list any known complications during/after your own birth _____

Please list any accidents, injuries, or surgeries you have had	Description	Date
Falls		
Head Injuries		
Motor Vehicle Accidents		
Broken Bones		
Surgeries		
Other		

What do you regularly do (or plan to do) to improve your life and health? _____

Please rate your personal or occupational life stress (1=Low, 10=High) 1 2 3 4 5 6 7 8 9 10

Please rate your commitment to your/your family's health (1=Low, 10=High) 1 2 3 4 5 6 7 8 9 10

Please rate yourself in each of the following categories: (circle)

EXERCISE	DIET	WORK ACTIVITY	REST	HABITS	PREVIOUS CHIROPRACTIC CARE
None	Poor	Sitting	Poor	Smoking	Poor
Moderate	Good	Standing	Good	Alcohol	Good
Daily	Excellent	Heavy Labor	Excellent	Caffeine	Excellent
Heavy		Repetitive Movement		High Stress Levels	

7 MEDICATIONS

Type	Purpose

VITAMINS/HERBS/MINERALS/SUPPLEMENTS

Type	Purpose

8 OFFICE POLICIES – By initialing, you agree to the office policies.

_____ ARRIVAL – Patients are seen in the order they arrive. Weekly office hours are posted, and all vistis are walk-in during office hours.

_____ FINANCIAL ARRANGEMENTS – We expect you to honor the financial arrangements you make with our office. Payment is due when services are rendered.

_____ PATIENT PRIVACY – I acknowledge that a copy of this office's Statement of Privacy Rights is available to me upon inquiry, and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

_____ PERTINENT INFORMATION – In the event of any future injury, surgery, sickness or drug usage, it is the responsibility of the patient to update this information with the chiropractor.

Momentum Chiropractic is a practice designed to keep individuals and families free from nerve interference caused by vertebral subluxations, to allow the body to more fully express its health potential. Chiropractic in this office consists of and is limited to: 1. analyzing the spine for the presence of vertebral subluxations; 2. directing specific forces into the spine for the body to use in the correction of vertebral subluxation; 3. educating and sharing the principles of chiropractic. Chiropractic is not a duplication of, substitution for, or alternative to medical care, and does not include any diagnosis, treatment, cure, or prevention of any medical condition. I have read the above, understand it completely and agree to become a practice member by these terms.

Signature_____ Date_____

Parent/Guardian Signature (if patient is a minor)_____ Date_____