WELCOME
To Carson Chiropractic, LLC

one

ABOUT YOU

Today's Date_____ File #:_____

Name:_____

What You Prefer To Be Called:_____ ❑Male ❑Female

Birthdate:___/___/___ Age:_____ SS#:_____

Race_____ Ethnicity _____

Home Address:_____

_____

CITY STATE ZIP

Home Phone #:_____

Cell Phone #s: _____

Employer:_____ How Long?_____

Employer Address:_____

_____

CITY STATE ZIP

Occupation:_____ Work Phone#:_____

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

Spouse's Name:_____

two

INSURANCE INFO

Co. Name:_____

Address:_____

Phone #:_____

Insured's SS#:_____

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

Insured's Name:_____

Relation:_____ Date of Birth___/___/___

Insured's Employer_____

Please inform front desk of 2nd Insurance company

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ❑Yes ❑No

If so, please explain:_____

The reason for this visit is a result of (Please Circle): work, sports, auto, trauma or chronic

(Explain what happened): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin?___/___/___

Is this condition getting worse? ❑Yes ❑No ❑Constant ❑Comes and goes

Is this condition interfering with your (Please Circle): work, sleep, or daily routine.

If so, please explain:_____

Have you had this or similar conditions in the past? ❑Yes ❑No

If so, please explain:_____

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

If so, where?_____

three

please continue on back.

IN EVENT OF EMERGENCY

Who should we contact?_____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Did anyone refer you?_____

HEALTH HISTORY

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y N	Claustrophobia (fear of small spaces)	Y N
Loss of bladder control	Y N	Spinal Surgery	Y N
Loss of bowel control	Y N	Common cold/flu	Y N
Temporary loss of vision, one eye	Y N	Carotid artery surgery	Y N
Blood in urine	Y N	Breast Removal	Y N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y N	Rheumatoid Arthritis	Y N
Stroke	Y N	Fractured/broken vertebra	Y N
Slipped Disc	Y N	Bleeding disorders	Y N
Herniated Disc	Y N	High blood pressure	Y N
Osteoporosis	Y N	Blood in stool	Y N
TIA's (pin or mini strokes)	Y N	Cancer	Y N
Drop attacks (collapsing, but not fainting)	Y N	AIDS	Y N
Hardening of the arteries	Y N	Kidney disease	Y N
Partial or complete paralysis	Y N	Prostate disease	Y N

Do you currently have, or could you be, any of the following?

Pregnant	Y N
Taking birth control pills	Y N
Receiving hormone therapy	Y N
❑ Male ❑ Female	
Receiving Chemotherapy	Y N
Receiving radiation therapy	Y N
Taking blood thinners	Y N
Do you smoke? Y N How long?_____	
In the last 6 mos have you tried to or thought about quitting?	Y N
Surgical/medical implanted devices:	
Aortic clips	Y N
Brain clips	Y N
Artificial heart valves	Y N
Rods pin, screws	Y N
IUD	Y N
Surgical clips/wires	Y N
Shunt	Y N
Neurosimulator	Y N
Dentures	Y N
Pacemaker	Y N
Hearing aid	Y N
Insulin pump	Y N
Joint replacement	Y N
Cochlear implants (ear)	Y N
Other implanted devices:	
Metal fragments (head, eye, skin)	Y N
Bullets/shrapnel	Y N
Body piercing	Y N
Tattoos	Y N

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y N
Vomiting	Y N
Vertigo (spinning)	Y N
Difficulty walking	Y N
Incoordination	Y N
Numbness or other sensory complaints	Y N
Loss of consciousness	Y N
Double vision	Y N
Blurred vision	Y N
Tinnitus (ringing in ears)	Y N
Speech problems	Y N
Clumsiness	Y N
Memory loss	Y N
Travel by car/truck	Y N
Personality changes	Y N
Fever	Y N
Recurrent headaches	Y N
Diarrhea	Y N
Used a tanning bed/booth	Y N
Skin rash/infection	Y N
A major fall	Y N
A minor fall	Y N
An auto accident	Y N
A work injury	Y N
Loss of strength	Y N
Pain moving bowels	Y N
Head trauma	Y N
Abnormal period	Y N

ACCOUNT INFO

Person ultimately responsible for account

Name:_____

Relation: _____

Billing Address _____

_____

CITY STATE ZIP

S.S #:_____

D.L. #:_____

Work Phone #:_____

Payment method:

❑Cash ❑Check ❑Credit Card

CC# (If Accepted)# _____

❑ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

- We invite you to discuss with us any questions 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 account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date____/____/____

Patient Name:_____ **Date:**_____ **DOB:**_____
Due to recent changes in the healthcare industry, we are asked to obtain the following information on patients treated in our office.

Address: _____ **City:**_____ **State:** _____ **Zip:**_____
Cell:_____ **Home:**_____ **Work:**_____ **Ex**_____

General Information:
Language: _____English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____
French _____ German _____ Russian _____ Other_____

Race: _____ White _____American Indian or Alaska Native _____ Asian
_____Native Hawaiian/Other Pacific Islander _____ Black or African American
_____ Hispanic or Latino _____ Decline to Answer

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

We may need to contact you, check which option you prefer us to use when contacting you:
Contact Preference: _____Hm Ph _____Wk Ph _____Cell Ph _____ Text Msg _____ Mail
_____Hm Email _____Wk Email

Patient History
Are you seeing anyone else for other problems or health conditions? ☐ Yes ☐ No
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____
_____
_____

Past health history

Have you…	Yes	No	If yes, include date & provider seen
...been hospitalized in the last 5 years?	☐	☐	
...been diagnosed with Diabetes Type I____or Type II_____	☐	☐	

Do you smoke? ☐Never ☐Former Smoker ☐Current/Every Day Smoker ☐Current Some Day Smoker

Medications
What medications are you currently taking? Include vitamins, herbs, minerals…
List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by
Please be as specific as possible

_____
_____
_____
_____
_____

Do you have allergies? ☐Food ☐Environmental ☐Medication
List Type of Allergy and Reaction

_____
_____
_____