

MOMENTUM CHIROPRACTIC - PRACTICE MEMBER INFORMATION

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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) YMCA Newspaper Flyer
 Internet Word of Mouth Phone Book 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 _____

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PHONE NUMBERS

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

Work Phone (____) _____ Other _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____ Phone (____) _____

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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. _____

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PATIENT CONDITION

Reason for Visit _____

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

When? _____ Where? _____

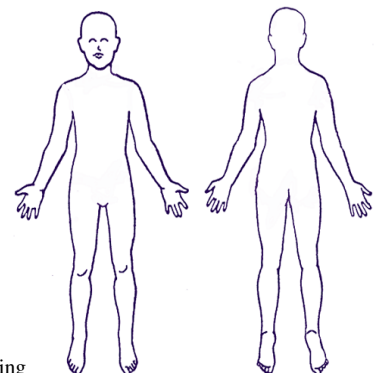
If you have no specific problem but are here for health maintenance, check here _____

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

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

Does it interfere with any of the following activities? (circle) Work Sleep Recreation Daily Routine

Activities or movements that are difficult to perform (circle) Sitting Standing Walking Bending Lying Down Lifting



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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	

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MEDICATIONS

Type	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

VITAMINS/HERBS/MINERALS/SUPPLEMENTS

Type	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

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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 appointments 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.
- ____ X-RAY – I have been fully informed of the possible dangers to me and unborn fetus that could result from an x-ray examination. To the best of my knowledge, I am **NOT PREGNANT** at this time. I hereby give they doctor permission to x-ray me today.
- ____ 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.
- ____ FAMILY POLICY – If you have children, your children's spines should be checked for subluxations too.
- ____ 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 _____