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 Patient Employer

Internet Another Provider Insurance 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

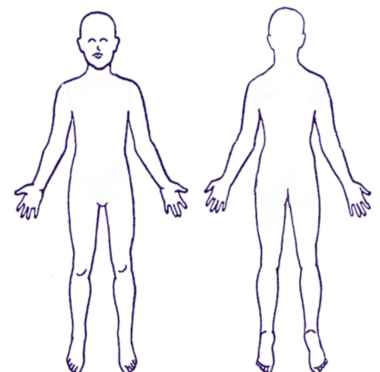
Reason for Visit____ Date it Started__________________________________

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:__________________________

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 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______________________________