Confidential Patient Information
(Please Print)

Date____________ Name________________________________Home Phone________________
Address________________________________ City_________________ Zip Code____________
Age____ Birth date___________ SS#_______________ E-mail address______________________
Marital Status: M S W D Children?__________________________Cell Phone_______________
Employer_____________________________ Occupation_________________________________
Insured's name (if patient is dependent)_____________________________DOB_______________
Name of Insurance Company_______________________ Address__________________________
Name of Spouse________________________________ Occupation_________________________
Employer____________________________ Address_____________________________________
Patient's Nearest Relative_________________________ Address__________________________
Referred By____
Is condition due to injury or sickness arising out of patient's employment?____________
Date symptoms appeared or accident happened___________
Patient ever had same or similar condition? _______ If yes, describe_______________________
Have you lost any days from work?_________ Date of last physical examination ______________
Females: pregnant? _________What operations have you had?______________________________
Serious illnesses?____

Have You Ever Suffered From (check all that apply):

__ Allergies	__ Poor Posture	__ Tuberculosis	__ Swelling of Ankles
__ Dizziness	__ Sciatica	__ Bruise Easily	__ Varicose Veins
__ Fatigue	__ Spinal Curvatures	__ Hay Fever	__ Bed Wetting
__ Headache	__ Swollen Joints	__ Nosebleeds	__ Frequent Urination
__ Loss of Sleep	__ Colon Trouble	__ Sinus Infections	__ Kidney Infection/stones
__ Ulcers	__ Diarrhea	__ Prostrate Trouble	__ Excessive menstrual flow
__ Hot Flashes	__ Difficult Digestion	__ Irregular Cycle	__ Cramps or backache
__ Numbness	__ Hemorrhoids	__ Pain over Heart	__ Lumps in breasts
__ Arthritis	__ Nausea	__ Poor Circulation	__ Alcoholism
__ Bursitis	__ Asthma	__ Rapid Heart beat	__ High Blood Pressure
__ Foot Trouble	__ Colds	__ Slow Heart beat	__ Low Blood Pressure
__ Low Back Pain	__ Deafness	__ Anemia	__ Venereal Disease
__ Ear Noises	__ Stroke	__ Diabetes	__ Neck Pain or Stiffness
__ Enlarged Thyroid	__ Eye Pain	__ Failing Vision	__ Polio
__ Chest Pain	__ Difficult Breathing	__ Pleurisy	__ Cancer

Tingling or Numbness in:

__ Shoulders __ Hips

__ Arms __ Legs

__ Elbows __ Knees

__ Hands __ Feet

Do You:

Now take Vitamins or Minerals?_________________

Think you may need Vitamins or Minerals? _________

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Habits:	Heavy	Moderate	Light	None
Alcohol	_____	______	____	_____
Coffee	_____	______	____	_____
Tobacco	_____	______	____	_____
Drugs	______	______	____	_____

Are you wearing. . .

Inner Soles ________

Heel Lifts _________

Arch Supports ______

Purpose of this appointment (Major Complaint)____
____
What Aggravates your Condition? ____
Is this condition getting progressively worse? Yes____ No_____ Constant____ Comes Goes____
Is this condition interfering with your. . . Work_____ Sleep____ Daily Routine____Other_____

How long has it been since you really felt good?_______________________________________
What do you believe is wrong with you?____
Other doctors seen for this condition?____
Have you been treated for any health condition by a physician in the last year? Yes____ No_____
Describe____
____
What medications are you taking?____
Remarks and additional information____
____
____

Payment is expected at time of visit

Name of person responsible for visit__________________________WDL#____________________

Are you insured? Yes___No____Insurance Company______________________________________

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately due and payable.

I further agree to pay all bills within 30 days. If I fail to pay all bills required, and if Bodle Chiropractic Clinic must resort to collection proceedings or legal proceedings to collect my bill, I agree to pay any and all costs for collection and/or reasonable attorney fees and costs incurred. Please note that in the event you fail to make payment when due, this account will be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Patient Signature Date
____

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