Confidential Patient Information
(Please Print)

Date: _____ Full Name (first, middle initial, last): _____

Phone: _____ Text Alerts? (please circle): YES or NO Driver License #_____

Address _____City _____State_____Zip Code_____

Age: _____ Birthdate: _____ Last 4 SSN#: _____ Email: _____

Marital Status (please circle): M S W D Number of Children? _____

Emergency Contact: _____ Phone: _____

Purpose of this appointment (Major Complaint) _____

What aggravates your Condition? _____

Is this Condition getting progressively worse? (please circle): Y or N

Is this Condition interfering with your (please check) Work ___ Sleep ___ Daily Routine ___ Other? _____

Other Doctors seen for this Condition?_____

Employer: _____ Occupation: _____

Are you insured? (please circle): Y or N Insurance Company: _____

Referred By: _____

Is condition due to injury or sickness arising out of patient's employment? (please circle): Y or N

Date symptoms appeared, or accident happened: _____

Has patient ever had same or similar condition? (please circle): Y or N If yes, please describe below:

_____

_____

Due to Injury, has patient lost any days from work? _____

Date of last physical examination? _____ Female: Are you pregnant? (please circle): Y or N

Have you had any medical operations? _____

Serious Illnesses: _____

If the patient is a Dependent:

Name of person responsible for your visit: _____ Driver License #_____

Have You Ever Suffered From?
(mark **"C"** for current, **"P"** for past, or **"B"** for both**):**

__ Allergy
__ Dizziness
__ Fatigue
__ Headache
__ Loss of Sleep
__ Ulcers
__ Hot Flashes
__ Numbness
__ Arthritis
__ Bursitis
__ Foot Trouble
__ Low Back Pain
__ Ear Noises
__ Enlarged Thyroid
__ Chest Pain

__ Poor Posture
__ Sciatica
__ Spinal Curvatures
__ Swollen Joints
__ Colon Trouble
__ Diarrhea
__ Difficult Digestion
__ Hemorrhoids
__ Nausea
__ Asthma
__ Colds
__ Deafness
__ Stroke
__ Eye Pain
__Difficult Breathing

__ Tuberculosis
__ Bruise Easily
__ Hay Fever
__ Nosebleeds
__ Sinus Infections
__ Prostate Trouble
__ Irregular Cycle
__ Pain over Heart
__ Poor Circulation
__ Rapid Heart Beat
__ Slow Heart Beat
__ Anemia
__ Diabetes
__ Failing Vision
__ Pleurisy

__ Swelling Ankles
__ Varicose Veins
__ Frequent Urination
__ Kidney Infection/Stones
__ Excessive Menstrual Flow
__ Cramps or Backache
__ Lumps in Breasts
__ Alcoholism
__ High Blood Pressure
__ Low Blood Pressure
__ Venereal Disease
__ Neck Pain or Stiffness
__ Polio
__ Cancer

Tingling or Numbness in:

__ Shoulders	__ Hips
__ Arms	__ Legs
__ Elbows	__ Knees
__ Hands	__ Feet

Habits	Heavy	Moderate	Light	None
Coffee:	___	___	___	___
Tobacco:	___	___	___	___
Drugs:	___	___	___	___
Exercise:	___	___	___	___

Current Medications & Supplements? _____
Additional information? _____
_____

<u>Payment is expected at the time of your visit</u>

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Bodle Integrative Health 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 that id I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I further agree to pay all bills within 30 days, I understand that interest will be charged to my account on all overdue accounts at the rate of 12%. If I fail to pay all bills required, and if Bodle Integrative Health must report to collection or legal proceedings to collect my bill, I agree to pay 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 with a 30% collection fee. In that event, the contingency fee assessed by the collection agency will be added to the principle 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:**

_____ _____