

Welcome!



Patient Information

Date _____
Please complete this form in ink. If you have any questions or concerns, please ask for assistance. We'll be happy to help.
(Please Print)
Name _____ Social Security # _____
Street Address _____ P.O. Box (street address also needed) _____
City _____ State _____ Zip _____
Do you prefer to receive phone calls at: home work cell no preference Best time to call _____
Home phone _____ Cell phone _____ Work phone _____
Do you have E-mail? Yes No E-mail address _____ (necessary for important notices & newsletters)
Age ____ Birthdate _____ Sex: M F Married Widowed Single Separated Divorced
Patient Employer/School _____ Occupation _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Work phone (____) _____
How did you hear of Melby Chiropractic? Website Newspaper Mailer Word of Mouth Other _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone (____) _____

Responsible Party

(if other than patient)

Name of person responsible for this account _____ Relationship to Patient _____
Phone (____) _____ Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work Phone (____) _____

Insurance Information

Name of policy holder _____ Relationship to patient _____
Policy Holder's Birthdate _____ Policy Holder's Social Security # _____
Name of employer (if not stated above) _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____

Health Information

Reason for visit: Wellness care Other: _____
Date of last physical exam _____
Women: Are you pregnant? Yes No Maybe Nursing? Yes No On birth control? Yes No
List any surgeries you have had and dates: _____

Allergies: _____

Health History

Check only those conditions that are applicable:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Measles | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arth. | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Disease | | <input type="checkbox"/> Scarlet Fever | |

Daily Habits

What type of exercise do you participate in? (ex: walking, running, aerobics, weight training, etc.) _____
_____ None

How often do you exercise? Less than weekly _____ X per week

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

What vitamins and nutritional supplements do you currently take? _____

Do you smoke? No Yes Pipe, cigar, cigarettes, other? _____ How much per day? _____

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, or my minor child, have insurance coverage with _____ (name of insurance co.) And assign directly to Melby Chiropractic Clinic 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.

Melby Chiropractic Clinic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient