ASBURY FAMILY Chiropractic

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(563) 582-3424 Fax (563)582-3566

Confidential Patient Application

Please invest a few moments to answer these questions so the Doctor can help you get better faster.

PATIENT INFORMATION:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) ____ - _____ Email: _____

Cell Phone: ( ) ____ - _____ SSN: _____ - _____ - _____

Sex: M or F Date of Birth: _____

Marital Status: S M D W Age: _____

Employer/Occupation: _____

Work Phone: ( ) ____ - _____

SPOUSE INFORMATION:

Name: _____ DOB: _____

Employer: _____ SSN: _____ - _____ - _____

Who may we thank for referring you our office? _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Health Concern	What have you tried to solve this concern?
1.	
2.	
3.	
4.	

Have you ever been to a Chiropractor? _____ If yes, how long ago? _____

This health condition is beginning to affect my….? (Or will affect)

A. Job	B. Marriage	C. Time
D. Kids	E. Self esteem	F. Finances
G. Future abilities	H. Sleep	I. Not Applicable

On a scale of 1 to 10, with 1 being no commitment and 10 being total commitment, how committed to getting well are you?

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Circle any of the following that are part of your health picture (past or present):

Allergies	Fibromyalgia	Cerebral Palsy	Digestive Disorders
Cancer	Multiple Sclerosis	ALS	Sinus Trouble
Tuberculosis	Convulsions	Nervousness	Backaches
High Blood Pressure	Epilepsy	Asthma	Numbness
Heart Trouble	Concussion	Dizziness	Arthritis
Diabetes	Hepatitis	Infertility	HIV positive
Headaches	Fatigue	Sleeping problems	Cold Sweats
Mood swings	Loss of smell	Buzz/ring in Ears	Depression
Irritability	Problems urinating	Hot Flashes	Heartburn
Menstrual pain	Menstrual irregularity	Loss of Balance	Fainting

What is the name of your regular Medical Doctor? _____

May We Update your Medical Doctor with our Exam Findings? YES NO

Please Provide Your Doctors Clinic Name/Address Here:

_____

_____

CURRENT LIST OF SURGERIES, MEDICATIONS, AND HISTORY OF TRAUMA

List all operations and their date:

1. _____
2. _____
3. _____
4. _____

Medications currently taking: (if more than four please provide list)

1. _____
2. _____
3. _____
4. _____

How stressful is your life? (1 = No stress | 10 = Extreme stress)

Occupation ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Personal ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

What do you feel is your primary stress? _____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your family:

Name	Age	Relation	Conditions

Do you have insurance? YES NO

If you have insurance please provide your ID Card when you return this form to the receptionist. As a courtesy we will file your insurance for you.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, whether or not my insurance company contributes. I hereby authorize the doctors at Asbury Family Chiropractic and whomever they may designate as their assistants to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct. By signing below I also acknowledge receipt of the privacy practices of this office.

_____ _____

Patient's (Parent or Guardian's) Signature Date