



Today's Date: _____

Please Print

Patient Number: _____

Patient Demographics

How did you FIRST hear about us? _____

Have you ever been treated by a chiropractor? Yes No

Have you ever been treated at any Charleston Neck & Back Center? Yes No

Legal First Name _____ Legal Last Name _____ Middle _____ Preferred First Name _____

Mailing Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Gender _____

Social Security # _____ / ____ / ____ Date of Birth _____ Driver's License # _____ State _____

Marital Status _____ Spouse's Name _____ Children (Names and Ages) _____

Emergency Contact

First Name _____ Last Name _____ Phone _____ Relationship _____

Employment Information

Employment Status _____ Employer Name _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ Occupation / Job Description _____

Insurance Information

Personal Health Insurance Carrier _____ Health ID card # _____ Group # _____

Policy Holder's Name _____ / ____ / ____ Policy Holder's Date of Birth _____ Policy Holder's Social Security # _____

Policy Holder's Employer _____

Primary Care Physician _____

Current Health Condition

 Please list the reason you have come to Charleston Neck & Back Center

 When did this begin?

 Has this ever occurred before?

 Have you seen other doctors for THIS CONDITION? If yes, who? (Name)

 Type of Treatment received for THIS condition?

 Were you satisfied with the results of your treatment? Explain

Is the Condition: Auto Related Job Related Home Injury

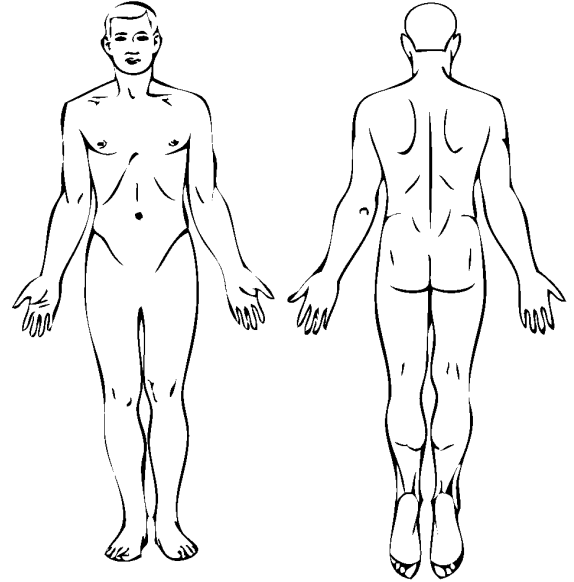
Slip or Fall Lifting Slept Wrong Unknown Cause

Other _____

_____/_____/_____
 Date of Accident Condition/Pain STARTED on what date?

LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

Use the letters BELOW to indicate the TYPE & LOCATION of your sensations right now.
Key: A=Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing



Are you currently pregnant? Yes No If yes, how long have you been pregnant? _____

Do you have a pacemaker or implantable cardioverter-defibrillator (ICD)? Yes No

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Do you SUFFER with ANY OTHER Condition than that which you are now consulting us?

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

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

 Consent to treat a Minor Date

 Guardian or Spouse's Signature of Authorizing Care Date

 Patient (Print Name) Patient's Signature Date