Volstad Chiropractic and Integrated Wellness

1
ONE

WELCOME

2
TWO

3
THREE

ABOUT YOU

Today's Date:_____/_____/_____ File #_____

Patient Name:_____
Last First M

What you prefer to be called:_____□ Female □ Male

Birthdate: _____/_____/_____ Age:_____ SS#:_____

Mailing Address:_____

_____
City State Zip

Home Phone#:_____

Work Phone#:_____

Cell Phone #:_____

E-Mail Address:_____

Referred By:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

Occupation:_____

Status:□ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name:_____

Do You have children? □Yes □No How Many?_____

INSURANCE INFO

Company name_____

Phone#:_____

Insured's SS#:_____

Policy#:_____

Group#:_____

Insured's Name:_____

Relation:_____

Date of Birth:_____/_____/_____

Insured's Employer:_____

Please inform front desk of 2nd. Insueance source.

REASON FOR VISIT

The reason for this visit is a result of (Please circle): work, sports, auto, trauma, or chronic.

(Explain what happened):_____

_____

Please describe the pain & its location:_____

_____

When did condition begin? _____/_____/_____

Is this condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Is this condition interfering with your (Please Circle): work, sleep, or daily routine.

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? □ Yes □ No

If so, where? _____

Have you ever been treated by a Chiropractor before? □ Yes □ No

If so, whom?_____Phone#:_____

4
Four

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #:_____Work Phone#: _____

Who is your Medical Doctor?_____ Phone_____

HEALTH HISTORY

Do you have or ever had any of the following:

Y N Heart Attack	Y N Heart Surg/Pacemaker	Y N Heart Murmer
Y N Shingles	Y N Cancer	Y N Arthritis
Y N Frequent Neck Pain	Y N Emphysema	Y N Anemia
Y N High/Low Blood Pressure	Y N Glaucoma	Y N Rheumatic Feve
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes	Y N Difficulty Breathing	Y N Chemotherapy
Y N Liver disease/Hepatitis	Y N Joint replacement	Y N Stroke

Please list all medications:_____

_____

_____

_____

Please list anything that you may be allergic to:_____

_____

List any past serious accidents with dates:_____

_____

Family Health History:_____

_____

Do you: Take Supplements or Vitamens?□ Yes □ No

Do you exercise regularly? □Yes □No

Are you on a special diet: □ Yes □ No if yes: Since: _____

Do you smoke? □ No □ Yes How Much?_____ How Long?_____

For Women: Are you taking Birth Control? □ Yes □ No

Are you pregnant? □ No □ Yes/How long?____ Nursing? □ Yes □ No

5
Five

6
Six

Person ultimately responsible for account

Name:_____

Relation:_____

Billing Address:_____

_____

City State Zip

SSN#:_____

D.L.#:_____

Work Phone #:_____

■ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

■ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

■ I Authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

■ I understand the above information and quarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date _____/_____/_____

□ Adult Patient □ Parent or Guardian □ Spouse