

Norton Chiropractic Wellness Center
Confidential Patient Information (please print)

Full Name: _____ Date: _____

Address: _____
Residence and mailing City State Zip

Home Telephone: () _____ Work Phone: () _____

Social Security #: _____ Drivers Lic.#: _____

Name of Spouse or Guardian: _____ **E-mail Address:** _____

Marital Status: M S W D Age: _____ Birthdate: _____ No. of Children: _____

Pregnant? _____ Height: _____ Weight: _____ Occupation: _____

Employer's Name and Address: _____

Spouse's Occupation/Employer: _____

Name of person responsible for payment: _____

Do you have insurance that covers Chiropractic care? Yes _____ No _____

Name of insurance company: _____ Group/Policy #: _____

Address: _____ Phone: () _____

WHO MAY WE THANK FOR REFERRING YOU: _____

List your problems or complaints according to <u>severity of pain</u>	Date started, or for how long	If you had the condition before, when?	Did Problem begin with an injury?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Is this condition interfering with: work sleep daily routine sports/exercise other _____

What aggravates your condition? _____

Other Doctor's seen for this condition? Medical Dr. Chiropractor Dentist Other _____

- Name _____ Address _____
When? _____ What did he say was wrong? _____
- Name _____ Address _____
When? _____ What did he say was wrong? _____
- Name _____ Address _____
When? _____ What did he say was wrong? _____

Are you taking any medications (drugs)? _____ What kind? _____

Have you had any x-rays taken? _____ When? _____ Where? _____ Area of body _____
When? _____ Where? _____ Area of body _____

Do you wear orthotics or heel lifts? ___ Yes ___ No

Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type _____ When _____ Hospitalized ___ Yes ___ No
2. Type _____ When _____ Hospitalized ___ Yes ___ No
3. Type _____ When _____ Hospitalized ___ Yes ___ No

NOTE: If you have RECENTLY been involved in an accident or injury, **please inform a staff member so they may bring you our accident report form.**

Have you had any surgery (please include all surgery)

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____
4. Type _____ When _____ Doctor _____

Have you ever been to a chiropractor?

What are your expectations with regard to today's visit?

What are your goals for care in this office?

CHECK any conditions you may have had in the **past**, and **CIRCLE** any **current** conditions

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Concentration Loss |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Eyes Sensitive To Light | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heavy Feeling of Head | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Leg Pain R/L | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Low Back Pain/Stiff | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Neck Pain/Stiff |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Pins/Needles Arms | <input type="checkbox"/> Pins/Needles Legs |
| <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Shoulder/Arm Pain R/L | <input type="checkbox"/> Sinus Problem |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Vision Problems | | |

Radiation of Pain Into Rt. Arm Lt. Arm Both
 Rt. Leg Lt. Leg Both

Aggravation of Pain Upon Walking Sitting Standing Bending Riding

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Matthew K. Norton, D.C. may prepare any necessary reports to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Matthew K. Norton, D.C. 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 understand that not all examination procedures are covered by all insurance carriers and agree to pay for these services in full if my insurance denies payment. I also understand that if I suspend or terminate my care and treatment, any fees for profession services rendered me will be due and payable within 30 days.

Patient Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Date of Auto Accident _____

Did vehicle have seatbelts? No Yes

Shoulder Belt Straps? No Yes

Were seatbelts worn? No Yes Shoulder Lap

List your riding position in vehicle: _____

If vehicle had headrests, describe the position compared to your head

Top of headrest aligned with top of head middle of head bottom of head

Briefly describe the impact collision

Head on Left Side Impact Right Side Impact Rear End Collision

List any parts of your body that made contact with vehicle part _____

Were you braced for impact? Yes No

Were brakes applied? Yes No

Were you looking up into inside rear view mirror? Yes No

Were you looking at outside door mirror? Yes No

Was your car stopped? Yes No

Any previous motor vehicle accidents? No Yes, Describe (include dates)_____

If yes, was treatment rendered previously? No Yes, Describe (include date and
Drs. name)_____

I do have medical coverage under my automobile policy. I understand that in most, but not all instances, benefits are paid directly to the Doctor at 100%. I also understand that I am ultimately responsible for all charges not covered, as the agreement is between my insurance company and myself. I understand that the Doctor's office will do all billing for me and my signature on this form serves as assignment of benefits for my insurance carrier and request that payment be made to Norton Chiropractic Wellness Center at the address shown on the claim form.

Patient Signature

Today's Date