Welcome to Beel Chiropractic Center

ABOUT YOU

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

Patient's Name: _____

What You Prefer to be Called: _____

Male: _____ Female: _____ Birth Date: _____ / _____ / _____

Age: _____ SS#: _____ - _____ - _____

Mailing Address: _____

City: _____ St: _____ Zip:_____

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-mail Address: _____

Referred by: _____

Employer: _____ How Long? _____

Employer's Address: _____

City: _____ St: _____ Zip: _____

Occupation: _____

Please complete all sections as completely as possible, and give this form to the Assistant at the front desk.

INSURANCE INFORMATION

Co. Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ DOB: _____ / _____ / _____

Insured's Employer: _____

Please inform front desk of 2nd Insurance source, if applicable.

Don't forget to complete Pages 2 and 3!

REASON FOR YOUR VISIT

The reason for this visit is the result of (Please circle): WORK SPORTS AUTO TRAUMA CHRONIC

Explain what happened: _____

Describe the pain and location: _____

When did the condition begin? _____ / _____ / _____

Is this condition getting worse? (Please circle) YES NO CONSTANT COMES & GOS

Is this condition interfering with your (Please circle) WORK SLEEP DAILY ROUTINE

If you have had similar conditions in the past, please explain: _____

Has a medical physician treated this condition? YES NO If so, where? _____

Have you ever been treated by a Chiropractor before? YES NO

If so, whom? _____ Phone #: _____

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Relation: _____ Home Ph # _____ Work Ph # _____

Who is your medical Doctor? _____ Dr.'s Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications? (Please circle all that apply)

Nerve Pills	Pain Killers (including aspirin)	Muscle Relaxers	Stimulants
Blood Thinners	Tranquilizers	Insulin	Other _____

Do you have or ever had any of the following diseases or conditions? (Please circle "Y" -or- "N.")

Y N	Heart Attack / Stroke	**Y N**	Heart Surgery / Pacemaker	**Y N**	Heart Murmur
Y N	Congenital Heart Defect	**Y N**	Mitral Valve Prolapse	**Y N**	Artificial Heart Valves
Y N	Alcohol / Drug Abuse	**Y N**	Venereal Disease	**Y N**	Hepatitis
Y N	HIV+ / Aids	**Y N**	Shingles	**Y N**	Cancer
Y N	Frequent Neck Pain	**Y N**	Emphysema / Glaucoma	**Y N**	Anemia
Y N	High / Low Blood Pressure	**Y N**	Psychiatric Problems	**Y N**	Rheumatic Fever
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 / Tuberculosis	**Y N**	Difficulty Breathing	**Y N**	Chemotherapy
Y N	Lower Back Problems	**Y N**	Artificial Bones / Joints	**Y N**	Arthritis

Please list any other serious medical condition(s) you have or have ever had:

_____

Please list anything you may be allergic to: _____

List any PAST serious accidents and dates: _____

Family Health History: _____

Do You: (Please circle) TAKE SUPPLEMENTS EXERCISE Are you on a special diet? YES NO Since: _____ / _____ / _____

Do you smoke? YES NO How Much? _____ How Long? _____

Are You wearing: HEEL LIFTS SOLE LIFTS INNER SOLES ARCH SUPPORTS

What is the age of your mattress? _____ Is it comfortable? YES NO

For Women:
Are you taking birth control? YES NO Are you pregnant? YES NO If yes, how long? _____ Nursing? YES NO

ACCOUNT INFORMATION

(Person ultimately responsible for this account)

Name: _____ Relationship to YOU: _____

Billing Address: _____ City: _____ St: ____ Zip: _____

Social Security #: _____ D.L. #: _____ State: ____ Work Phone #: _____

Payment Method: (Please Circle) CASH CHECK CREDIT CARD CC#: _____ Exp: _____ / _____

- 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 in 90 days of the date of service and no financial arrangements have been made, you will be responsible for all 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 information required to process insurance claims.
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsible to inform this office of any changes to the information I have provided.**

SIGNATURE:_____ DATE: _____

Circle ONE: Adult Patient Parent / Guardian Spouse

Pain Chart

Beel Chiropractic Center

ABOUT YOU

Patient's Name: _____ File #: _____

What is your current weight? _____ lbs. What is your current height? _____ Ft. _____ In..

Please describe your condition: _____

_____

_____

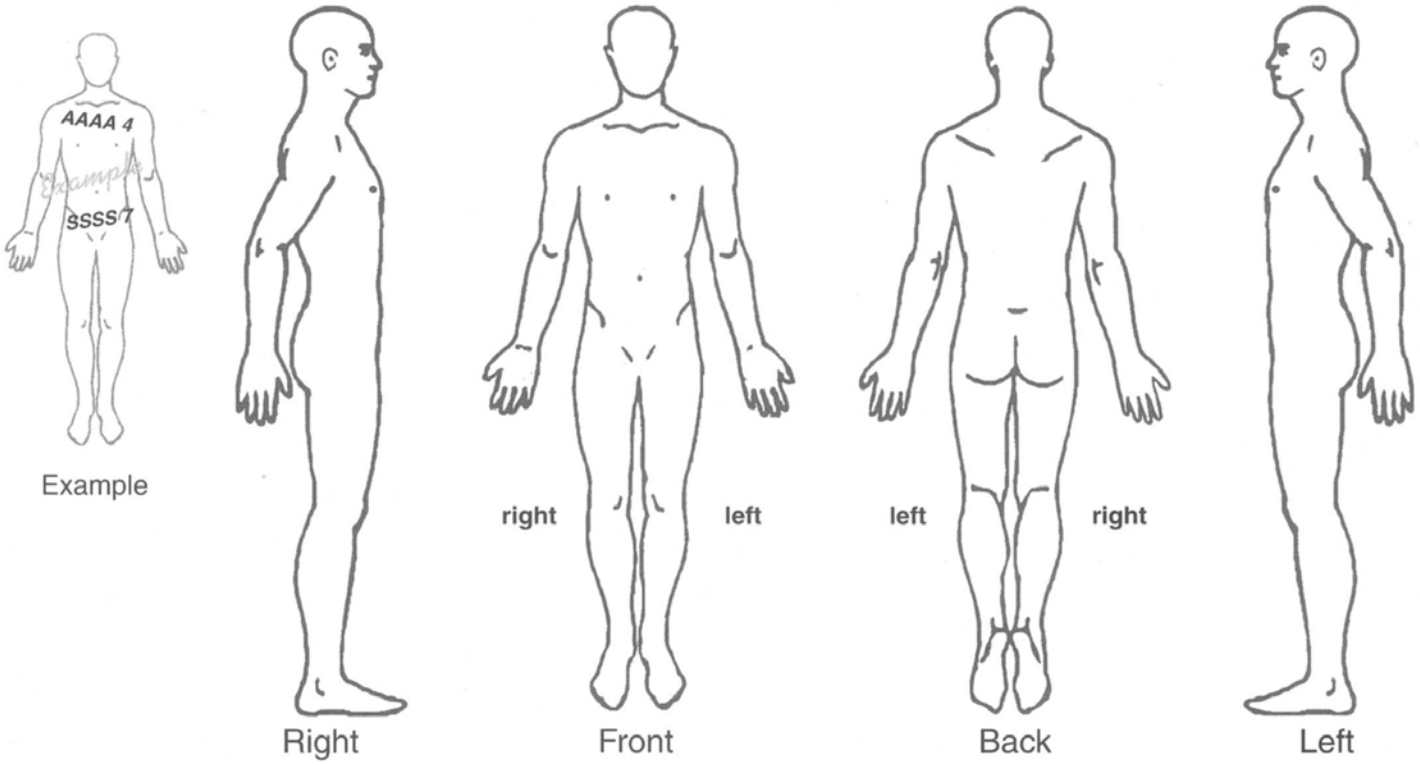
Signature: _____ Today's Date _____ / _____ / _____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

_____

_____

_____

_____

_____