Sleigh Family Chiropractic:
A Creating Wellness
Center

Name:_____

What You Prefer to Be Called: _____

❑ Male ❑ Female Birth Date:___/___/___ Age:_____

Address:_____Apt. #:_____

City:_____State:_____ Zip Code:_____

Please circle the phone number(s) that is(are) the best to contact you:

Cell: ( )_____ Home: ( )_____

❑ I would like to opt out of receiving SMS messages and appointment reminders. I understand that Sleigh Family Chiropractic will no longer be able to communicate with me through SMS text messaging.

Email Address:_____

Employer:_____Occupation:_____

Marital Status: ❑ married ❑ single ❑ divorced ❑ widowed

Spouse's Name:_____ Occupation:_____

Children's Names and
Ages:_____

_____

If Minor: Mother's Name:_____ Father's Name:_____

Family Doctor's Name:_____ Phone:( )_____

Referred By:_____

PAYMENT INFORMATION:

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the insurance coverage.

Insured's Name:_____ Insured's Birth Date: _____

Insurance Company:_____ Insured's ID:_____

❑ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Current Condition

Have you had previous chiropractic care? When? _____

Reason for visit_____

When did your symptoms appear?_____

How did this condition develop? (fall, accident, gradual, sudden, etc) _____

Is your condition getting worse over time?_____ Have you had the same/similar problems before?_____

Have you seen other doctors for this complaint?_____ Name:_____

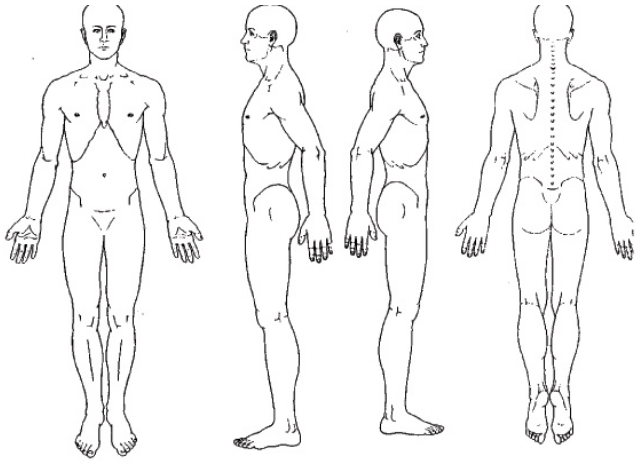
What percent of awake hours does it affect you? less than 25% ___ 25% ___ 50% ___ 75% ___ 100% ___

Does it interfere with your: ( ) work ( ) sleep ( ) daily routines ( ) recreation ( ) other _____

Activities which are painful: ( ) standing ( ) sitting ( ) lying down ( ) walking ( ) bending

Type of pain: ( ) sharp ( ) dull ( ) throbbing ( ) numbness ( ) aching ( ) shooting ( ) burning ( ) tingling ( ) cramps ( ) stiffness ( ) swelling

Pain Location



Health History

Please mark with an X to indicate if you have any of the following diseases/medical conditions.

If condition happened in the past, please indicate by marking with a "P".

AIDS/HIV ( )
Alcoholism ( )
Allergy Shots ( )
Ankle/Foot Pain ( )
Anemia ( )
Anorexia ( )
Appendicitis ( )
Arthritis ( )
Artificial Bones/Joints ( )
Asthma ( )
Bleeding disorders ( )
Breast Lump ( )
Bronchitis ( )
Bulimia ( )
Cancer ( )
Cataracts ( )
Chemical dependency ( )
Congenital Heart Defect ( )
Diabetes ( )
Difficulty Breathing ( )
Diverticulosis ( )
Dizziness ( )
Ear Problems ( )
Emphysema ( )
Epilepsy ( )
Fractures ( )
Gall Stones ( )
Glaucoma ( )
Goiter ( )
Gout ( )
Headaches (frequent) ( )
Heart Attack ( )
Heart Disease ( )
Heart Murmur ( )
Hepatitis ( )
Hernia ( )
Herniated Disc ( )
High Cholesterol ( )
High/Low Blood Pressure ( )
Hip/Leg Problems ( )
Irritable Bowel Syndrome ( )
Jaw Problems ( )
Kidney disease/problems ( )
Knee Pain ( )
Liver disease/problems ( )
Lower Back Pain ( )
Menstrual Problems ( )
Mid Back/Rib Pain ( )
Migraines ( )
Miscarriage ( )
Mitral Valve Prolapse ( )
Multiple Sclerosis ( )
Neck Pain ( )
Osteoporosis ( )
Pacemaker ( )
Parkinson's ( )
Pelvic Pain ( )
Polio ( )
Prostate problems ( )
Psychiatric Care/Problems ( )
Rheumatic Fever ( )
Sciatica ( )
Scoliosis ( )
Seizures ( )
Shingles ( )
Shoulder/Arm Problem ( )
Sinus Problems ( )
Stomach Problems ( )
Stroke ( )
STD ( )
Suicide attempts ( )
Thyroid problem ( )
Tonsillitis ( )
Tuberculosis ( )
Tumors ( )
Ulcers ( )
Whiplash ( )
Wrist/Elbow/Hand Pain ( )

Please list any other medical condition(s) you have: _____

_____

Please list ALL medications that you are taking (prescription and non-prescription): _____

_____

Are you under the care of any other healthcare provider or doctor? ❑ Yes ❑ No

If yes, please provide name(s) and type(s) of doctor: _____

Please list anything that you may be allergic to: _____

_____

Please list all previous surgeries/treatments with dates: _____

_____

Please list any and all accidents with dates (car accidents, falls, broken bones, concussions, etc.):

_____

_____

How would you rate your diet? ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Do you exercise regularly? ❑ Yes ❑ No If yes, How much? _____ times/week How long? _____

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Custom orthotics ❑ Arch supports

What is the age of your mattress? _____ **Is it comfortable?** ❑ Yes ❑ No

Work Habits: ( ) sitting ( ) standing ( ) repetitive bending ( ) light labor ( ) heavy labor

Other Habits: ( ) smoking - quantity _____ ( ) drinking - quantity _____

( ) coffee/caffeine - quantity _____ ( ) stress - reason _____

For Women: Are you taking birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If yes, how long? _____ Are you nursing? ❑Yes ❑ N

❖ 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 service and no financial arrangements have been made, you will be responsible for any 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 to release any 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 responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____/_____/_____