

(Please Print)

PATIENT'S NAME _____ SOC SEC # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL: M S D W #CHILDREN _____ HEIGHT _____ WT _____

PHONE # _____ WORK # _____ x _____ CELL# _____ EMAIL _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER ADDRESS _____

SPOUSE'S NAME _____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ WORK PHONE _____

WHO CAN WE THANK FOR REFERRING YOU? _____

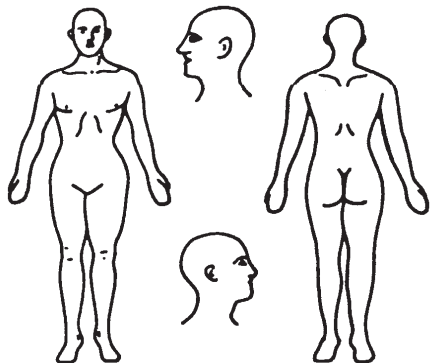
NAME AND ADDRESS OF NEAREST LIVING RELATIVE _____
 (NOT LIVING WITH YOU)

Purpose of this appointment _____

Have you seen any physician for this condition (check all that apply) Chiropractor MD None

What medications are you taking? _____

Please mark your areas of pain below:



List conditions that you are most interested in getting corrected in order of importance and when each started.

1. _____
2. _____
3. _____
4. _____

Women: Are you pregnant at this time?

Yes No

What functions are you unable to perform or induce pain upon performance? (example: sit, bend, walk)

1. _____
2. _____
3. _____
4. _____

List surgeries and years

Have you suffered from:

- | | | |
|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Press | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Probs |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neck Pain |

Have you ever had chiropractic care before? Yes No

Doctors name _____

Present Family Doctor _____

Have you been treated for any health conditions by a physician in the last year? Yes No

Address _____

Date of last Physical exam _____

If it determined that your health could be improved, would you want to receive chiropractic care at this office?

Yes No

By Whom _____

IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE COMPLETE THIS SECTION

IS YOUR CASE: Workers Compensation No Fault (Auto accident) Personal Injury

Date of Injury: _____ Time: _____ Location: _____

Please describe how the injury happened: _____

Did you report your injury? Yes No To whom? _____

Were you Hospitalized? Yes No Where? _____

By ambulance? Yes No X-rays taken? Yes No By whom? _____

Date(s) of hospitalization _____ Medications prescribed _____

Are You presently working? Yes No Dates of time lost from work _____

Have you been treated by any other chiropractor or physician for this injury? Yes No If yes, Doctor's name and specialty _____

List any previous injuries:

1. Type _____ When _____ Hospitalized Yes No

2. Type _____ When _____ Hospitalized Yes No

INSURANCE INFORMATION (Please Print)

Do you have health insurance? Yes No If yes:

Name(s) of insurance company(s) _____

Address _____ Policy # _____

Spouses Insurance Company name _____

Address _____ Policy # _____

PAYMENT ACKNOWLEDGEMENT (Please sign)

I understand and agree that my health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Charschan's office will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and any amount authorized to be paid directly to Dr. William Charschan's office 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 payments, co-payments and non-covered managed care services. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the case of managed care plans, I agree to abide by the protocols designed by my plan and understand that any care not authorized by my plan is my responsibility. Charschan Chiropractic will do their best to preauthorize all my care and I am fully responsible for any care not preauthorized by my carrier.

If I violate this agreement and Dr. Charschan's office sends my account to a collection agency or attorney for collection, I will be responsible for all collection and court costs as well as yearly interest on the unpaid balance.

Patient's (or legal guardian) signature _____ Date _____

Insured Signature _____ Date _____