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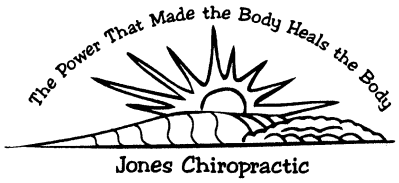
**Acct#**_____
**Claim#**_____




3311 Bethel Rd. SE, Suite 6A Port Orchard, WA 98366

## PATIENT

Last Name: _____ First Name: _____ Middle: _____
Gender: □ M □ F Date of Birth: ___/___/___ Age: _____ Weight:_____ Height:_____
SS#: _____ Drivers License #:_____
Home Address: _____ Apt #:_____
City: _____ State: _____ Zip:_____
Email Address:_____
Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____
Occupation:_____ Employer Name:_____
Employer Address: _____ City_____ State_____ Zip_____

## SPOUSE or GUARDIAN

Last Name:_____ First Name:_____ Middle:_____
Employer Name:_____ Work Phone #:_____
Date of Birth: ___/___/___ Social Security #:_____

## REASON FOR THIS VISIT

Describe the purpose of this visit
Is the purpose of this appointment related to:
□ Job □ Sports □ Auto □ Fall □ Chronic Discomfort □ Home Injury □ Other
Please Explain:_____

If job related, have you made a report of your accident to your employer? □ Yes □ No
When did this condition begin?_____

Has this condition □ Gotten worse □ Stayed constant □ Comes and goes
Does this condition interfere with: □ Work □ Sleep □ Daily Routine
Explain:_____

Has this condition occurred before? □ Yes □ No
Explain:_____

Have you seen other doctors for this condition?
□ Yes □ No Dr's Name:_____ Type of Treatment_____

## EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office?_____
Have you been adjusted by a Chiropractor before? □ Yes □ No
Reason for those visits?_____
Doctor's Name _____ Approximate Date of Last Visit _____
Has any adult in your family seen a Chiropractor? □ Yes □ No
Has any child in your family seen a Chiropractor? □ Yes □ No

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## AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:

- Doctors of Chiropractic work with the nervous system? □ Yes □ No
- the nervous system controls all bodily functions and systems? □ Yes □ No
- Chiropractic is the largest natural healing profession in the world? □ Yes □ No
- if Chiropractic care started at birth, a higher level of health is achieved? □ Yes □ No

## GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Dr. Jones will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ **Relief Care** – Symptomatic relief of pain or discomfort
□ **Corrective Care** – Correcting and relieving the cause of the problem as well as the symptoms
□ **Comprehensive Care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

□ I want Dr. Jones to select the type of care appropriate for my condition.

_____

Patient's Signature Date

## MEDICATIONS I NOW TAKE

□ Nerve Pills □ Pain Killers (including Aspirin) □ Muscle Relaxers
□ Blood Pressure Medicine □ Insulin □ Stimulants
□ Blood Thinners □ Tranquilizers □ Other

## HEALTH HABITS

| | | | | |
|---|---|---|---|---|
| Do you smoke? | □ No | □ Yes _____packs/day | | |
| Do you drink alcohol? | □ No | □ Yes _____drinks/day | | |
| Do you drink coffee? | □ No | □ Yes _____cups/day | | |
| Do you exercise regularly? | □ No | □ Moderate | □ Daily | |
| Do you wear | □ Heel Lifts | □ Sole Lifts | □ Inner Soles | □ Arch Supports |

## HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

□ Severe or Frequent Headaches
□ Loss of Sleep
□ Numbness/Pain in Arms/Legs/Hands
□ Ulcers/Colitis
□ Heart Surgery/Pacemaker
□ Difficulty Breathing
□ Alcohol/Drug Abuse
□ Psychiatric Problems
□ Sinus Problems
□ Pain Between the Shoulders
□ Lower Back Problems
□ Heart Attack/Stroke
□ Heart Murmur
□ Asthma
□ Venereal Disease
□ Thyroid Problems
□ Dizziness
□ Frequent Neck Pain
□ Digestive Problems
□ Congenital Heart Defect
□ High/Low Blood Pressure
□ Arthritis
□ Rheumatic Fever

## FOR WOMEN

| | | |
|---|---|---|
| Are you pregnant? | □ Yes | □ No |
| Are you nursing? | □ Yes | □ No |
| Are you taking birth control? | □ Yes | □ No |
| Do you experience painful periods? | □ Yes | □ No |
| Do you have irregular cycles? | □ Yes | □ No |
| Do you have breast implants? | □ Yes | □ No |

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# AUTHORIZATION FOR CARE

I hereby authorize Dr. Jones to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Dr. Jones will not be held responsible for any pre-existing medically diagnosed conditions nor for nay medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient's Signature Date Guardian or Spouse's Signature Authorizing Care Date

## Who should receive bills for payment on your account?

□ Patient □ Spouse □ Parent □ Worker's Comp

□ Personal Health Insurance □ Auto Insurance

## Ownership of X-ray Films

It is understood and agreed that the payments to Dr. Jones for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

## IN AN EMERGENCY PLEASE CONTACT

Name_____ Relationship_____

Work Phone_____ Home Phone_____

Cell Phone_____ Other Instructions_____

# ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that JONES CHIROPRACTIC will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to JONES CHIROPRACTIC will be credited to my account on receipt.

Insurance Co. Name_____ Member ID#_____

Address_____ Member/Provider Services Phone #_____

## ABOUT THE INSURED PERSON

Name_____ Insured's Social Security#_____

Relationship_____ Date of Birth_____

Employer_____