Welcome to Schreck Chiropractic & Wellness

Please take a few moments to give us some information about yourself so that we can serve you more efficiently. Please print all information as clearly as possible. Thank you.

Patient Information

First Name: _____ MI: _____
Last Name: _____
Birthdate:_____ Age:____ Gender: M F
Social Security Number: _____
Address: _____
City: _____ State: _____
Zip Code: _____
Email: _____
Home Phone: (_____)_____
Work Phone: (_____)_____
Cell Phone: (_____)_____
Occupation: _____
Employer: _____
Name of Spouse: _____

Emergency Contact: _____
Relationship: _____ Phone: _____
Address: _____

Whom may we thank for referring you?

_____
(The person who referred you will receive a complimentary gift)

Accident Information

Is this condition due to an accident? ☐Yes ☐ No
Date of accident? _____
Type of accident? ☐Auto ☐Work ☐Home ☐Other
To whom have you made a report of your accident?
☐Auto Insurance ☐Employer ☐Worker Comp.
☐Other
Attorney Name (if applicable)_____
_____

HABITS

☐Y ☐N Smoking Packs/Day _____
☐Y ☐N Alcohol Drinks/Week _____
☐Y ☐N Coffee/Caffeine Drinks/Day _____
☐Y ☐N High Stress Reason _____

Insurance

Insurance Company: _____
Account #: _____
Group #: _____
Subscribers Name: _____
Relationship to Patient: _____
If not 'self', please include: (of subscriber)
Birthdate: _____
SSN: _____
Is Patient covered by additional insurance? Y / N
Insurance Co.: _____
Group #: _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with:

_____
and assign directly to:

Schreck Chiropractic and Wellness all insurance benefits, if any, otherwise payable to me for services rendered.* I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named clinic may use my health care information and may disclose such information to the above named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

*SCHRECK CHIROPRACTIC AND WELLNESS is a 'Participating' Medicare provider. If I am using Medicare I acknowledge that I understand I will be expected to pay for all services not covered by Medicare.

_____
Please Print Name of Patient, Parent or Guardian

_____
Signature of Patient, Parent or Guardian

Date: _____

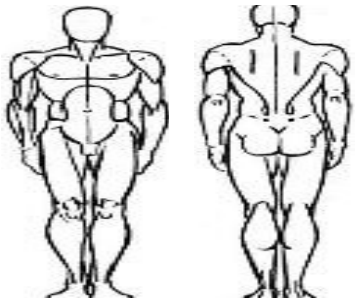
SCHRECK CHIROPRACTIC AND WELLNESS

Patient Name: _____
elementalchiropractic.com

Patient Condition

Reason for Visit: _____
When did the complaint start?_____
Have you had a similar condition in the past? ☐Yes ☐No
Is this condition getting worse? ☐Yes ☐No
Is pain? ☐Constant ☐Intermittent
Does it interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Is it painful to: ☐Sit ☐Stand ☐Walk ☐Bend ☐Lie Down
Have you seen a Chiropractor before? ☐Yes ☐No When_____
Severity of Pain? Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

Please mark painful area(s) with an 'X'.



Health History

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic ☐None ☐Other Describe:_____

Name of other Doctor(s) who has treated you for your condition: _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam_____ MRI, CT-Scan, Bone Scan _____

Are you Pregnant? ☐Yes ☐No ☐NA Due Date: _____ Date of last Menstruation: _____

Check 'Yes' or 'No' to indicate if you have had or currently have any of the following?

☐Y☐N Heart Attack/Stroke	☐Y☐N Arthritis	☐Y☐N Ringing in Ears
☐Y☐N Ulcer/Colitis	☐Y☐N Frequent Neck Pain	☐Y☐N Severe/Frequent Headaches
☐Y☐N Gout	☐Y☐N Jaw Pain	☐Y☐N Alcohol/Drug Abuse
☐Y☐N Diabetes/TB	☐Y☐N Wrist Pain	☐Y☐N Dizziness
☐Y☐N Fainting/Seizures	☐Y☐N Shoulder Pain	☐Y☐N Arm Pain
☐Y☐N Psychiatric Problems	☐Y☐N Leg Pain	☐Y☐N Kidney Problems
☐Y☐N Difficulty Breathing	☐Y☐N Lower Back Problems	☐Y☐N Artificial Bones/Joints
☐Y☐N Hepatitis	☐Y☐N Severe/Frequent Earaches	☐Y☐N Cancer
☐Y☐N Anemia	☐Y☐N HIV Positive/AIDS	Other _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____