North Valley Chiropractic
"We listen, we care, we get results!"

Confidential Patient Information

Section I: Patient Information **Date_____**

Name:_____ Home Phone _____Cell Phone _____
Address:_____City:_____State:_____Zip_____
Date of Birth:_____ Age _____ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Social Security Number:_____ E-mail Address:_____
Employer_____ Occupation _____ Work Phone _____
Address:_____City:_____State:_____Zip_____
Spouse's Name:_____ #of Children_____
Whom may we thank for referring you? _____
Have you ever had Chiropractic before ☐ Yes ☐ No If yes, when and where _____

Section II Insurance Information

Is this injury or illness related to ☐ Employment ☐ Auto Accident ☐ Other, please explain _____
Date of injury:_____ Location: _____
Workers Compensation Insurance Co._____ Phone: _____
Your Auto Insurance Co._____ Phone: _____
Third Party Insurance Co._____ Phone: _____
Do you have Health Insurance? ☐ Yes ☐ No Insured Name _____ Date of Birth:_____
Primary Insurance Company _____ Phone: _____
Secondary Insurance Company _____ Phone: _____

Section III Treatment Authorization

All charges are due when services are rendered.
Method of Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

Why Chiropractic?
People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested In having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your need and desires when recommending your treatment.

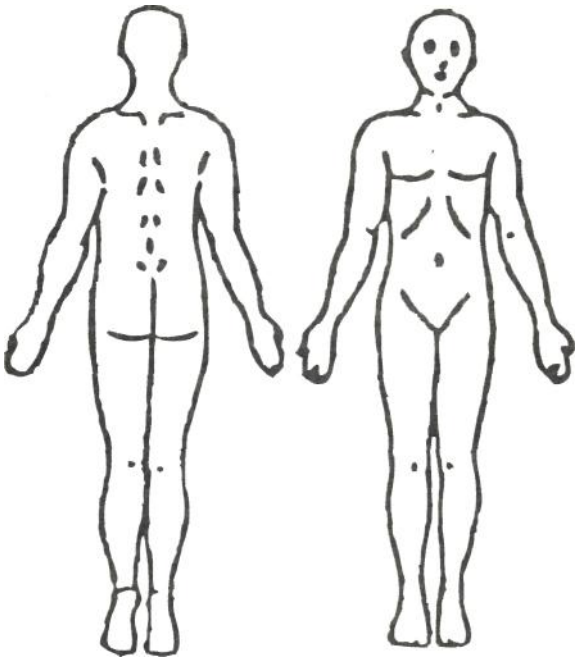
RELIEF CARE
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE
Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length and time, but is more lasting.

I authorize North Valley Chiropractic to render necessary services to me and I am responsible for all charges incurred.
Patient Signature _____ Date _____
Guardian authorizing care_____

THANK YOU FOR ALLOWING US TO SERVE YOU!

PLEASE MARK AN **X** ON THE DIAGRAM
WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt? (Attach additional pages if needed)

List your chief complaints in order of severity

1. _____
2. _____
3. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

Check and of the following you have had in the last six months

( ) Headaches
( ) Sinus Congestion/Allergies
( ) Vision problems
( ) Ear Aches
( ) Dizziness
( ) Heart Problems
( ) Lung Problems/Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate/Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Numbness
( ) Frequent Nausea/Vomiting
( ) Abdominal Cramps
( ) Constipation
( ) Diarrhea
( ) Poor/Excessive Appetite
( ) Excessive Thirst
( ) Painful/Excessive Urination
( ) Discolored Urine
( ) Diabetes
( ) Cancer

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure