Chiropractic First, Family Wellness Center

<u>Confidential New Member Information</u>

Date:________________

Name:______________________________________ Home Phone:_____________ Work/Cell:____________

Address:_______________________________City/State/ZIP:_______________________________________

D.O.B.:___________ Age: ____ Who may we thank for referring you? _____________________________

Is this for the whole family? Family:_____ Self: ________ Medicare? Yes No Car Accident? Yes No

Primary reason for consulting our office:____

Occupation:_____________________________________ Employer: __________________________________

Sex: M / F Single / Married / Divorced / Widowed Spouse's Name:________________________________

Name and Ages of Children:____

Email: ____Social Security Number:__________________

Your hobbies/interests/activities: ____

Do you exercise? NO YES: How often? ______________ What type?__________________________________

Rate your diet: Healthy Average Poor Do you use Vitamins/Supplements: YES NO__________________

Alcohol: Never/Rare/Moderate/Daily Smoker? No Yes ___# packs/day since year: ___ Past smoker? No Yes

What is the present reason for consulting our office?

Symptom Relief Maintaining Your Current Level of Health Optimum Wellness

Previous chiropractic care? YES NO If yes, Dr.'s Name: ________________________ Last visit? _________

Other doctors you are currently seeing: ____

Current medications:____

Over the counter drugs taken in the past 3 months: ____

List all surgeries:____

List all accidents and falls: ____

Health is the most valuable asset in the world – YOU and YOUR FAMILY'S. Healing includes taking responsibility for that health. Aspects of this responsibility are attending the classes, following your care plan, and meeting your financial obligations. The insurance industry pays for the treatment of symptoms and disease. We do not treat symptoms and disease. We offer true healing through Chiropractic Care. Therefore we operate on a fee for service basis. However, you may submit your claims for your own personal reimbursement. Chiropractic care is not a treatment, nor cure of disease. Chiropractic care is for the restoration and maintenance of full function and communication within the body, from the brain to every cell in the body, so that you may express your full potential for life and healing.
I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone authorized by the same doctor. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read this consent and intend this consent form to cover the entire course of my care and any care in the future.

Signature:____________________________ Witness:_________________________

Print:________________________________ Date:_________________