# Randour Chiropractic Clinic

Name: _____

SSN:_____ Marital Status:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Gender: Male - Female

Insurance Company: _____ Policy # _____

Policy holder's Name:_____ Relation:_____DOB: _____

Emergency Contact Name:_____ Phone:_____

How did you hear about Randour Chiropractic?_____

***Preferred Language**:_____ Height_____ Weight_____

***Smoking Status**: □ Everyday □ Some days □ Former Smoker □ Never

***Race**: □Amer. Indian □Asian □African American □Native Hawaiian □White Other_____

***Ethnicity**: □ Hispanic or Latino □ Non- Hispanic or Latino

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: _____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ *High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Stomach Problems □ Tumor □ Ulcer(s) □ Wrist Pain

□ Other: _____

*List all **Medications** you are currently taking and reason: _____

_____

_____

*Are you **allergic to any medications**? _____

_____

_____

List your **Immediate Family Medical History**: (Example: Mother – High blood pressure)

_____

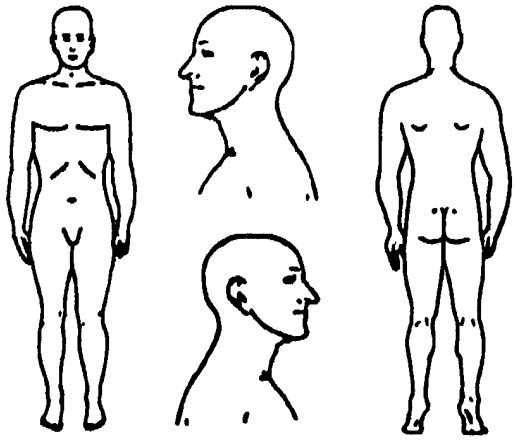
_____

List any other accidents that you have had (auto, sports, etc):

_____

_____

*PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW*



*What is your MAJOR complaint and the date the problem began?

_____

_____

_____

*What is your SECOND complaint and the date the problem began?

_____

_____

_____

*What is your THIRD complaint and the date the problem began?

_____

_____

_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am responsible for any balance not paid by my insurance company. Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and other expenses in collecting your account. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information provided.

Signature_____Date_____

☐Adult Patient ☐Parent/Guardian