Crested Butte Sports Chiropractic

Date: ____ / ____ / _____

File #: _____

Client Information

Personal Information

Patient Name: _____ Preferred Name: _____

Birthdate: _____/_____/_____ Age: ____ ☐ Male ☐ Female SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Email: _____

Status: ☐ Minor ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single Children: ☐ Yes ☐ No How Many: ___

Spouses Name: _____ Referred By: _____

Emergency Information

Name: _____ Relation: _____

Daytime Phone: _____ Evening Phone: _____

Medical Doctor: _____ Phone: _____

Employment Information

Employer: _____ Occupation: _____ How Long:_____

Reason For Visit

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic

Explain what happened: _____

Please describe the pain & it's location: _____

_____

When did condition begin: _____/_____/_____ Is it getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine Explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No Date: _____/_____/_____

Have you ever been treated by a medical physician for this condition? ☐ Yes ☐ No

If so, where? _____

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

If so, whom? _____ Phone #: _____

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Health History

Are you taking any of the following medications? (Please check all that apply.)

☐ Nerve Pills ☐ Pain Killers (Including Asprin) ☐ Muscle Relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s)

Do you have or ever had any of the following conditions? (Please check all that apply.)

☐ Heart Attack ☐ Heart Surgery/Pacemaker ☐ Heart Murmur ☐ Congenital Heart Defect
☐ Mitral Valve Prolapse ☐ Artificial valves ☐ Alcohol/Drug Abuse ☐ Venereal Disease
☐ Hepatitis ☐ HIV+/AIDS ☐ Shingles ☐ Cancer
☐ Frequent Neck Pain ☐ Emphysema/Glaucoma ☐ Anemia ☐ High/Low Blood Pressure
☐ Psychiatric Problems ☐ Rheumatic Fever ☐ Severe/Frequent Headaches ☐ Kidney Problems
☐ Ulcers/Colitis ☐ Fainting/Seizures/Epilepsy ☐ Sinus Problems ☐ Asthma
☐ Diabetes/Tuberculosis ☐ Difficulty Breathing ☐ Chemotherapy ☐ Lower Back Problems
☐ Artificial Bones/Joints ☐ Arthritis

Please list any other serious medical conditions you have or ever had: _____

_____

Allergies: _____

_____

Previous surgeries/treatments with dates: _____

_____

Any past serious accidents with dates: _____

_____

Family health history: _____

_____

_____

Do you take supplements/vitamins? ☐ Yes ☐ No Exercise? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No Since: ____/____/_____ Do you smoke? ☐ Yes ☐ No How Much? ____

Do you wear: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

What is the age of your mattress? _____ Is it comfortable? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No How Long? _____ Nursing? ☐ Yes ☐ No

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Account Information (Person Ultimately Responsible For Account)

Name: _____ Relation: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ D.I.#: _____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

Credit Card Number: _____ Exp. Date: _____ Initial Here: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Insurance Information

Address: _____ City: _____ State: _____ Zip: _____

Insured's ID#: _____ Group # (Plan, Local, Policy #): _____

Insurance Company's Phone #: _____

Insured's Name: _____ Relation: _____

Birthdate: _____/_____/_____ Insured's Employer: _____

Please inform the front desk of second insurance source.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business 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, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse