

Settimi Chiropractic Center

Please Print Clearly and Fill In Completely

Print Name _____ Email _____
Street Address _____ Phone _____
City _____ State _____ Zip _____ Date of Birth _____ Age _____

Please Circle One: Sex: Male Female Right Handed Left Handed

Social Security # _____ Driver's License # _____
Business Employer _____ Type of Work _____
Business Phone: _____

Please Circle One: Single Married Separated Divorced Widowed

Name of Spouse _____ Spouse's Employer _____
Type of Work: _____ Business Phone: _____

Name and Ages of Children: _____

Referred to this Office By: _____
Name and Number of Emergency Contact: _____
Relationship to You: _____

Please Check: Who Is Responsible For Your Bill, You and:

Spouse Worker's Comp Auto Insurance Medicare Medicaid

A photocopy of your insurance card and driver's license will be needed at the time of your first visit.

Current Health Condition

Unwanted Health Condition: _____
Other Doctors Seen For This Condition: _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin: _____ Has This Condition Occurred Before _____
Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made A Report Of Your Accident To Your Employer: Yes No
Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers
 Blood Pressure Medicine Insulin Other: _____
Do You Wear a Shoe Lift? Yes No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

Past Health History

Please Circle and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
Broken Bones Other: _____

Major Accidents or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: Yes No

Doctor's Name and Approximate Date of Last Visit: _____

Wellness Commitment:

At Settimi Chiropractic Center, we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this, we need to understand our commitment toward being healthy. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10%---20%---30%---40%---50%---60%---70%---80%---90%---100%

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come 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 you needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care **Corrective Care**

Check here if you want the doctor to select the type of care appropriate for your condition

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____

Date _____

Consent to Treat A Minor _____

Date _____

Guardian or Spouse's

Signature of Authorizing Care _____

Date _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | Intake |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |
- Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestions
- Varicose Veins
- Ankle Swelling
- Stroke

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____
Are you pregnant?
 Yes No Not Sure

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

FAMILY HISTORY

The following members have the same or similar problem as I do:
 Mother
 Father
 Brother
 Sister
 Spouse
 Child