Please complete this informational sheet so that we can accurately process your appointment.

Due to recent changes in the healthcare industry, we are asked to obtain the following information on patients treated in our office. All information will be kept confidential and is not distributed to unauthorized parties and according to HIPPA policies.

Name:_____

Date of Birth:_____ **Social Security #:**_____

Address:_____

City/State/Zip:_____

Phone: Home:_____ Cell:_____

Email: _____ **Best way to be reached:**_____

Emergency contact:_____

Emergency contact phone:_____

Circle One For Each

Marital Status: Single Married/Partnership Divorced Separated Widowed

Spouse's Name:_____

Primary Language: English Spanish Other_____ Declines to answer

Your Occupation: _____ **Employer:**_____

Name of Primary care

Physician:_____Phone:_____

Height:_____ Weight:_____

Circle One For Each

Have you had previous Chiropractic care? YES NO

What is your major complaint/
injury?_____

Have you had any Diagnostic Imaging? YES NO
Where?:_____

Are your injuries accident related? YES NO AUTO WORK OTHER:
_____

When did you problem
begin?_____

Since your symptoms began, they have: (circle all that apply)

Increased Decreased Stayed the same

Your symptoms are: Always present Frequent Occasional On and off

How bad is your pain or ache? 1 2 3 4 5 6 7 8 9 10

Describe your pain: Sharp Shooting Dull/Ache Stiff Tingling Numbness Throbbing

Other_____

What makes your symptoms
better?_____

What makes your symptoms
worse?_____

Other Doctors who treated this condition?
_____

List any
surgeries:_____

Current
Medications:_____

Allergies:
_____

Have you been hospitalized in the last 5 years? YES NO
When/Why?_____

Have you been diagnosed with Diabetes YES NO If yes, TYPE I TYPE II

Circle One For Each

EXERCISE: NONE MODERATE DAILY HEAVY

WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR

HABITS: SMOKING ALCOHOL COFFEE/CAFFEINE DRINKS HIGH STRESS

Please check to indicate if you have any of the following:

( ) Weight gain or loss
( ) Nausea/Vomiting
( ) Weakness
( ) Decreased hearing
( ) Abdominal pain
( ) Numbness
( ) Earaches
( ) Ringing in ears
( ) Diarrhea
( ) Tremor
( ) Kidney Stones
( ) Blurry/Double vision
( ) Heartburn
( ) Sinus pain
( ) Constipation
( ) Burning/Pain w/urination
( ) Blood in urine
( ) Prostate issues
( ) Incontinence
( ) Anxiety
( ) Depression
( ) Shortness of breath
( ) Cancer
( ) Hallucinations
( ) High blood pressure
( ) Calf pain
( ) Palpitations
( ) Leg cramping
( ) Seizures
( ) Aortic Aneurysm
( ) Dizziness
( ) Stroke

INSURANCE INFORMATION:

Please provide Insurance card(s) and Driver's License or Photo ID. If Workers Comp or No Fault, see below:

PRIMARY INSURANCE: _____ POLICY #:_____

NAME OF INSURED AND DATE OF BIRTH:_____

INSURED EMPLOYER:_____

SECONDARY INSURANCE:_____POLICY #:_____

NAME OF INSURED AND DATE OF BIRTH:_____

INSURED EMPLOYER:_____

No-Fault Information (Auto-Related)

N/F Carrier:_____DOA: _____Claim#:_____

Adjustor Name/Phone: _____

Attorney Name/Phone: _____

Workers Compensation (Work-Related Accident)

W/C Carrier:_____DOA:_____WCB#:_____

Carrier Case #: _____ Adjustor's name/phone: _____

We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services at the time of visit unless other arrangements have been made. 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 any other expenses incurred in collecting your account. I authorize the provider to release any

information required to process/secure insurance claims/benefits, and I assign all applicable insurance benefits directly to Wiebke Chiropractic Care PC. I understand the above information and guarantee this form was completed 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.

Who may we thank for this referral?

_____

Signature of Patient or Legal Representative

_____

Date:_____