AHC
Alternative Healthcare Center
The Chiropractic Group™

CONFIDENTIAL

PATIENT INFORMATION

NAME:_____ S.S. #_____ SPOUSE:_____
(LAST) (LEGAL FIRST) (I)

PARENTS' NAME: *(if patient is a minor)*_____ REFERRED BY:_____

SEX: M or F MARITAL STATUS: M S D W SEP. BIRTHDATE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: HOME: ( )_____ WORK: ( )_____

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

INSURANCE INFORMATION

INS. CO.:_____

INSURED:_____

GROUP #_____

S.S. #_____

POLICY #_____

DEDUCTIBLE: $_____

COPY OF BOTH SIDES OF CARD:

YES NO

I hereby authorize Alternative Health Care to release any information necessary to process this claim and ASSIGN ALL BENEFITS payable directly to the doctor.

Signature_____

Guardian
Signature (if minor)_____

Date:_____ Witness:_____

WORK COMP

Date of Injury:_____

S.S. #_____

Employer Name & Address:

_____

_____

_____

Telephone: ( )_____

Whom do we contact? (Boss)

_____

I authorize payment of medical benefits to Alternative Health Care.

Signature_____

AUTO. ACCIDENT

Date of Accident:_____

Ins. Name & Address:

_____

_____

_____

Telephone: ( )_____

Agent:_____

Claim #_____

I authorize payment of medical benefits to Alternative Health Care.

Signature_____

** Please advise the doctor and the receptionist if you have had an accident or injury. **

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____

(Please complete back page)

HEALTH QUESTIONNAIRE

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS_____

_____

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION_____

_____

Have you ever been under Chiropractic Care? ☐ *Yes* ☐ *No* *Doctor's Name*_____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What activities aggravate your condition?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other_____

Please circle the number that best describes your pain 0 1 2 3 4 5 6 7 8 9 10

No Pain Medium Severe

How long has it been since you really felt good?_____

Have you been treated for any health conditions by a medical doctor in the last year? ☐ Yes ☐ No

If yes, for what condition?_____ Name of Doctor:_____

What prescription medications are you taking?_____

Have you had any x-rays in the last year?_____ If yes, why?_____

MEDICAL HISTORY *(If any of the following are relevant to **your** medical history, please check the accompanying box.)*

☐ CANCER	☐ GERMAN MEASLES	☐ DIZZINESS	☐ ASTHMA
☐ POLIO	☐ VENERAL DISEASE	☐ ARTHRITIS	☐ DIGESTIVE DISORDERS
☐ TUBERCULOSIS	☐ MUSCULAR DISTROPHY	☐ NEURITIS	☐ SINUS TROUBLE
☐ HIGH BLOOD PRESSURE	☐ MULTIPLE SCLEROSIS	☐ RHEUMATISM	☐ BACKACHES
☐ HEART TROUBLE	☐ CONVULSIONS	☐ RHEUMATIC FEVER	☐ NUMBNESS
☐ DIABETES	☐ EPILEPSY	☐ SCARLET FEVER	☐ ANEMIA
☐ HEPATITIS	☐ CONCUSSION	☐ NERVOUSNESS	

Which of the following MOST CLOSELY matches your current health goals?

☐ I am only interested in getting rid of my symptoms.

☐ I am interested in fixing the underlying cause of my current health problems.

☐ I am interested in being as healthy as I can be, and take an active interest in my health.

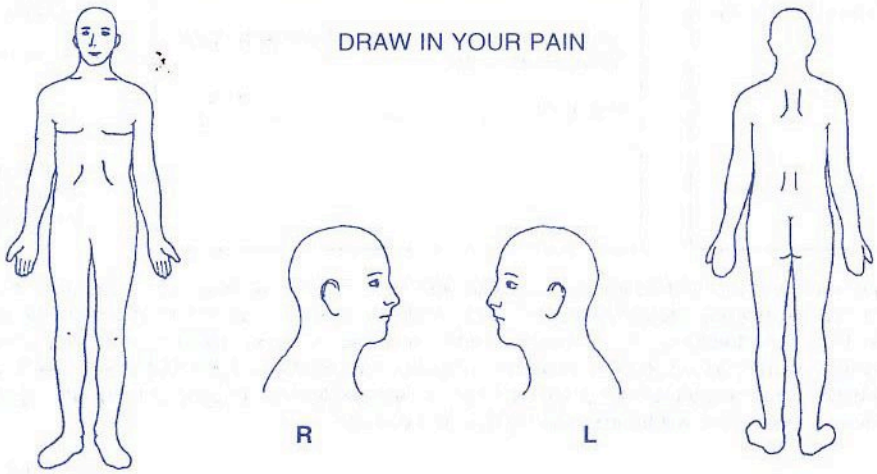
I AM ALSO INTERESTED IN ACUPUNCTURE YES____ NO____ NUTRITION? YES____ NO____

DESCRIBE THE OPERATIONS YOU'VE HAD:_____ WHEN?_____

ARE YOU PREGNANT? ☐ YES ☐ NO # PREGNANCIES_____ # CHILDREN_____

WAS THE DELIVERY DIFFICULT?_____

DRAW IN YOUR PAIN



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