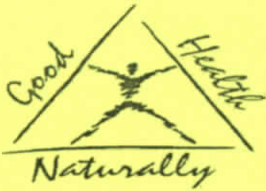


# Clear Choice Chiropractic

*of Niles, PC*

## CONFIDENTIAL PATIENT INFORMATION

This information is strictly confidential. If we do not sincerely believe that you will respond favorably to chiropractic care we will not accept your case, but will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely. If you have any questions don't hesitate to ask one of our staff members for help. Thank You.

Date__________ Name__________________________________________ Phone__________________

E-mail______________________________ SS#________________ Age ________ Birthdate____________

Address______________________________ City________________ State________ Zip Code ________

Sex: Male / Female Marital Status: S M W D Do you have children? __________ If yes, how many? __________

If female, are you pregnant? Yes No Date of last menstrual cycle______________________________

Occupation ________________________ Employer ________________________________________

Work Address ______________________________ Work Phone ______________________________

Name of Spouse______________________________ Spouses Occupation ________________________

Spouses Employer______________________________ Work Phone ____________________________

Name of Nearest Relative ____________________________ Phone ______________________________

How did you hear about our office? (If another patient, please give name) ____________________________

Have you ever been to a doctor of chiropractic before? Y N If yes, please list doctor's name and phone number and date of your last visit______________________________________________________

Please list any surgeries you have had (type/date/doctor/remarks) ________________________________

______________________________________________________________________________

Please list any broken bones (date/remarks) ____________________________________________

______________________________________________________________________________

Please list previous traumas, accidents and falls: ______________________________________

______________________________________________________________________________

List any medications or any diet supplements you are currently taking including over-the- counter drugs__________

______________________________________________________________________________

______________________________________________________________________________

**Please circle ANY of the following which have ever affected you:**

| | | | |
|---|---|---|---|
| Allergies | Ear pain | Low back pain | Pain in the eyes |
| Asthma | Fainting | Malaise/Fatigue/Weakness | Pelvic Pain |
| Bed wetting | Fever/Chills | Menopause | Ringing in the ears/Dizziness |
| Breast Problems | Flank Pain | Mid Back pain | Seizures |
| Depression | Headaches | Muscle cramps/weakness | Sinusitis |
| Difficulty Breathing | Hip Pain | Nausea/Vomiting | Shortness of Breath |
| Difficulty chewing | HIV positive | Neck Pain | Tics/Spasm |
| Difficulty swallowing | Indigestion/Heartburn | Nose Pain | Venereal Disease |
| Dramatic weight change | Joint pain/Swelling | Nosebleeds | Visual Problems |

**Please circle ANY of the following which have ever affected you or anyone in your family:**

| | | |
|---|---|---|
| Cancer | Heart Disease | Liver/Kidney Disease |
| Diabetes | Hypertension/High Blood Pressure | Stroke |

Do you regularly drink alcohol? Yes No Do you smoke or use other tobacco products? Yes No

## ABOUT YOUR CURRENT CONDITION

Reason for contacting our office ______________________________

When did this condition first begin? ______________________________ Is your condition getting worse? Yes No

Is your present condition the result of any Auto Accident or Work Related Injury? Yes No

How did this condition arise? Please describe ______________________________

______________________________

______________________________

Other doctors consulted for this condition

______________________________

______________________________

**Please shade in any areas of pain or injury on the figures below:**

| For Office Use Only |
| --- |
| Initiating |
| Aggravated |
| Diminished |

◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆

## INSURANCE INFORMATION

Name of Insured ______________________ SS # ______________________

Policy Number ______________________________

Name of Insurance Company ______________ Contact Person ______________ Phone ______________

Address ______________ City ______________ State ________ Zip Code ______________

**Secondary Insurance Company**

Name of Insured ______________________ SS # ______________________

Policy Number ______________________________

Name of Insurance Company ______________ Contact Person ______________ Phone ______________

Address ______________ City ______________ State ________ Zip Code ______________

◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆

I here by instruct and direct my insurance company and or attorneys to make payment for services rendered directly to :

**Clear Choice Chiropractic**
**P.O. Box 725 Niles, MI 49120**

If my insurance carrier prohibits direct payment to this clinic, then I hereby also instruct and direct my insurance company to make the check out to me and mail it as follows:

**Clear Choice Chiropractic**
**P.O. Box 725 Niles, MI 49120**

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee and I further agree I will pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

**A photocopy of this agreement shall be considered as effective and valid as the original document.**

I authorize the release of any information pertinent to my case to all insurance carriers, adjusters or attorneys directly involved with my case.

Signature ______________________ Date ________ Witness Signature ______________________ Date ________