Whole Family Chiropractic
160 NE Maynard Rd, Suite 204 Cary, NC 27513

Personal Data:

Patient Name_____ Date of Birth_____ E-Mail_____

Address_____ City_____ State_____ Zip____

SS#_____ Home #_____ Work #_____ Cell #_____

Employer_____ Address_____ Zip____

Spouse_____ DOB_____ SS#_____ # of Children_____

Spouse's Employer_____ Address_____ Zip____

Nearest Relative Not Living With You_____ Phone_____

Who may we thank for referring you?_____

Purpose of this Appointment? List Your Complaints. _____

_____

What makes the condition(s) better or worse? _____

_____

Date of Illness/Injury _____ Where did it occur? _____

Is Injury/Illness Related to ___ Auto Accident ___ On the Job ___ Other (explain) _____

Who is responsible for payment? ___ Self ___ Spouse ___ Other (resp. party) _____

Patient's Insurance

Name of Co._____

Address _____

City, State, Zip _____

ID & Group # _____

Phone # _____

Spouse's Insurance

Name of Co. _____

Address _____

City, State, Zip _____

ID & Group # _____

Phone # _____

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that Whole Family Chiropractic will prepare all necessary reports and forms to assist me in making collection from the insurance company and that ay amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable. There is a 1-1/2% service charge plus any reasonable collection fees on any unpaid balance.

Consent of Professional Services and Release of Information

I hereby authorize Dr. Bell and whomever she may designate as their assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic procedures and any other services that they deem necessary in my case. I further authorize Dr. Bell to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to me or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Privacy Notice

I acknowledge that I have received a copy of Whole Family Chiropractic's privacy notice. Initials:_____ Date:_____

Patient Signature_____ **Parent/Guardian Signature**_____

Witness Signature_____

Whole Family Chiropractic

Patient Name _____ Date _____

Are You ___ Overweight ___ Under Weight ___ Average

Exercise ___ Not Really ___ Sometimes ___ Regularly What type? _____

Smoke or chew tobacco? ___ Yes ___ No

Do you drink less than 6 glasses of water daily? ___ Yes ___ No How much? _____

Are you commonly fatigued or tired? ___ Yes ___ No Explain _____

Circulatory Problems? ___ Yes ___ No Explain _____

Skin conditions? ___ Yes ___ No Explain _____

Allergies/Asthma? ___ Yes ___ No Explain _____

Do you get sick easily or often? ___ Yes ___ No Explain _____

Sinus problems? ___ Yes ___ No Explain _____

Do you get headaches? ___ Yes ___ No How often? _____ Where? _____

Digestive problems? ___ Yes ___ No Describe _____

What is the age of your mattress? _____ In what position do you sleep? _____

How many hours of sleep do you get each night? _____

Please list all of the medications/vitamins you are currently taking: _____

_____

Would you like to learn more about: ___ Overall health ___ Prevention ___ Lifestyle Changes

What have you done to maintain your spine and nervous system? _____

Do you have regular dental check-ups? ___ Yes ___ No

Do you have the oil in your car changed regularly? ___ Yes ___ No

Please list any major stress factors (traumas, work, chemicals, family): _____

Please list the major health problems of your immediate family, including children:

Name	Relationship	Age	Health Problem(s)

Please mark your area(s) of pain on the right and describe below:

_____

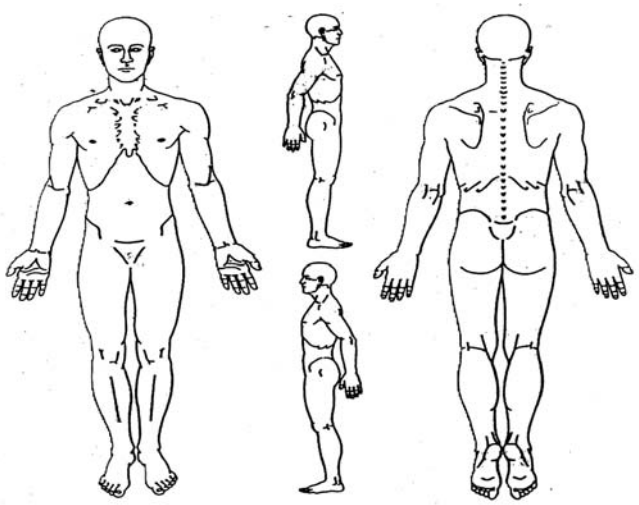
_____

_____

_____

_____

_____



Signature _____