ROBERTS CHIROPRACTIC CENTER
INITIAL INTAKE & HEALTH STATUS

Patient Name ____ Sex: **F / M**

Address ___________________________ City/State ____________ Zip ________

SS# _______________ Birthdate _____________ Martial Status: **S M D W**

Phone _____________ Cell _____________ Email Address _______________

Occupation ___________ Employer _______________ Work Phone ___________

INSURANCE INFORMATION

Primary Ins Co ____

Insured ID # _______________ Group # ___________

Subscribers Name ____________________ Subscribers DOB __________

Subscribers relation to patient : **self spouse child other**

Subscribers Employer (subscriber is other than patient) ______________________

Secondary Ins Co ____

Insured ID # ________________ Group # __________

Subscribers Name ____________________ Subscribers DOB __________

Subscribers relation to patient : **self spouse child other**

Subscribers Employer (subscriber is other than patient) ______________________

CURRENT MEDICAL

Major complaint ________________ Date of Onset _________ Is this? **Work / Auto Related**

Is this condition: Improving **Unchanged Getting Worse**

Is this condition interfering with your: **Work Sleep Daily Routine**

What makes your condition better? ____________________________________

What makes your condition worse? ____________________________________

PAIN SCALE

NO PAIN **0 1 2 3 4 5 6 7 8 9 10** UNBEARABLE PAIN

Have you had any **SPINAL XRAYS, MRI, CT SCANS** for your area(s) of complaint? **Y / N** If yes,

When / Where ____

Have you ever been treated by a chiropractor before? **Y / N**

If yes, **WHO / WHEN** ____

Who is your family physician? ____________________________________ Phone #____________________

List all Medications: ____

____

Surgeries: ____

Other Health Problems: ____

____

PLEASE CHECK ALL THAT APPLY TO YOU:

___ Diabetes **___ Heart Attack / Stroke** **___High Blood Pressure** **___Cancer**

___Migraine **___Epilepsy / Seizures** **___Urinary Problems** **___Prostate Problems**

___Arthritis **___Artificial bones / Joints**

PLEASE CHECK ALL THAT APPLY TO YOUR FAMILY HISTORY:

___ Diabetes **___ Heart Disease** **___High Blood Pressure** **___Cancer** **___Arthritis**

___Epilepsy / Seizures

IN GENERAL WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS :

EXCELLENT VERY GOOD GOOD FAIR POOR

Please check the one that best describes your current goal for your Health and Well- Being.

___ I am only concerned about the relief of my current complaint.

___ I am only concerned about the relief of my current complaint and preventing its return.

___ I want optimum **HEALTH and WELL-BEING** on every level available to me.

The undersigned agrees to and understands all information of this agreement. I accept financial responsibility for services given regardless of insurance reimbursement to provider. Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with Roberts Chiropractic Center. If account is not paid within 90 days and no financial agreement have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection your account.

I hereby consent to the performance of examination and treatment on by the licensed doctor of chiropractic, certified therapy assistant, and any other technical support staff who may be employed or engaged in practice in this clinic. I understand that while very small , there are certain degrees of risk associated with chiropractic care and with any supportive physical therapeutic modalities. These risk include , but are not limited to fracture, stroke, disk injury, sprains, strains, and soreness. I am therefore willing to accept and consent to the risk associated with the care I am about to receive.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any change to the information I have provided.

Patient Signature ____ **Date** _______________________