



Welcome To Our Clinic!

AGREEMENT TO PROVIDE CHIROPRACTIC SERVICES

Patient Information

Date: _____

Patient Name: (Last): (First): Birthdate: Address: City: State: Zip: Social Security #: Driver's License #: Home Phone: Cell Phone: Email: Age: Ht: Wt: Marital Status: Spouse's Name: (Parent/Guardian): Your Occupation: Employer: Address: Work Ph#: Whom may we thank for referring you?

Insurance Information

Primary Who is responsible for this account? Relationship to Patient: Insurance Company: Insured's Name: Group #: ID #: Is there Secondary Insurance? Nature of Condition? Automobile Work Home Sports Other

Method of payment you plan to use to cover today's charges? Check Cash MasterCard Visa

X-Ray Confirmation: This is to confirm that I have been informed by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographs for the purpose of diagnosis and treatment.

Notice: Not all patients require x-rays to determine diagnosis, type of treatment or length of treatment. The radiographs taken are for the purpose of analysis and diagnosis. They are property of this office and are a part of your permanent records.

Consent to Treat a Minor Child: I hereby authorize Performance Chiropractic to administer chiropractic and athletic injury services as deemed necessary to my child.

Patient or Legal Guardian

Covenant to Pay Charges and Interest: I recognize that Performance Chiropractic "PCPC" is not a party to any agreement between my insurance carrier and myself. I recognize PCPC will process the necessary forms and documentation for collection from my insurance provider to an extent reasonable. I recognize that any benefits paid directly to PCPC will be credited to my account upon receipt unless prohibited by law or other contractual arrangement. PCPC is further authorized to endorse my name on any document that contains my name where legally entitled to do so.

I unconditionally recognize and affirm that I am wholly liable for the payment of any expenses or costs resulting from treatment or services incidental thereto rendered by PCPC. I accept and affirm that upon default of payment by me, written notice of default shall be sent by PCPC within a reasonable time thereafter.

I have read the above terms. I understand and accept the above terms.

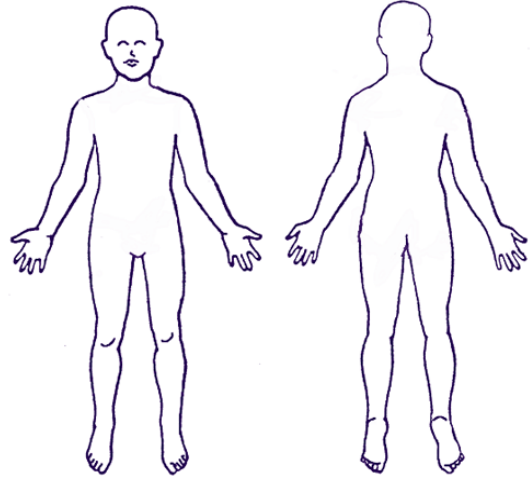
Patient or Legal Guardian

Performance Chiropractic, P.C.

Patient Health Information

Reason for Visit: _____

Please show where you are having symptoms, conditions, or problems with an X:



When did your condition appear?

Is this condition getting worse? Yes No

Describe the symptoms you are experiencing?

Pain: Sharp Dull Shooting Burning
 Aching Tingling Other

Appearance: Swelling Discoloration

Activities that make condition worse:

Sitting Standing Bending Lying

What have you tried to help the above?

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Services None Other

Please list medications: _____

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Tobacco
- Alcohol
- Coffee/Caffeine
- Other

Please check 'Yes' or 'No' to indicate if you have had any of the following:

Aids/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Injuries/Surgeries you may have had (Description & Date): _____

Medications/Allergies/Vitamins/Supplements: _____
