



Name: _____ DOB: _____ Age: _____ Home Phone: _____
Address: _____ City, State, Zip: _____
Employer: _____ Employer Address: _____
Status: Married, Single, Widowed, Divorced Spouse/Significant other name: _____
Children's names/ages: _____
Emergency Contact Name: _____ Number: _____ Employer: _____
Email Address: _____
Reason for consulting our office at this time: _____
Name of person responsible for payment: _____
Do you have insurance coverage? Yes No If yes, which company: _____
How did you hear about us? _____

Please initial the following that are applicable:

This is to certify that Ten Lakes Chiropractic Clinic has my permission to take X-rays. _____

Female Patients: This is to certify that to the best of my knowledge I am NOT pregnant. _____

ACKNOWLEDGEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. Furthermore, I understand that although I have assigned insurance benefits to Ten Lakes Chiropractic Clinic, it is likely and probable that my insurance coverage will be less than the amount billed. I acknowledge that it is my responsibility to pay the balance of my bill once insurance benefits have been received. I clearly understand and agree that it is probable that my insurance plan will not pay for all charges incurred in this office. I acknowledge that I am responsible for any charges refused by my insurance company. 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. Further, I will pay for any collections or legal charges incurred in the collection of any uncovered charges should I fail to pay them during the agreed upon time. I acknowledge that I am aware of Ten Lakes Chiropractic Clinic's Privacy Notice. It is posted in the facility for me to read or I may request a paper copy of the Privacy Notice upon request to the Ten Lakes Chiropractic Clinic's Privacy Officer. Your signature is required to be compliant with HIPAA regulations

THERE WILL BE A \$50 CHARGE FOR CANCELLATIONS LESS THAN 24 HOURS AHEAD OF TIME AND PAYMENT IS EXPECTED AT TIME OF SERVICE

The statements made on this form area accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Name

SS#

Signature/Parent/Guardian

Date

BALANCING LIFE NATURALLY



Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____
 Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT C – CONSTANT	O F C	GASTRO-INTESTINAL	O F C	CARDIO-VASCULAR
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heart beat
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Distension of abdomen		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heart beat
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall bladder trouble		RESPIRATORY
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite		SKIN
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily
		EYES, EARS, NOSE & THROAT		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental Decay		GENITO-URINARY
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noises		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inability to control kidneys
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection or stones
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble		FOR WOMEN ONLY
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive menstrual flow
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nosebleeds		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopausal symptoms
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge
				<input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?

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CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping cough |

PLEASE PRINT

List surgical operation and years: _____

Drugs you now take: _____

Have you been in an auto accident: Past year Past five years Over five years Never
Describe: _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU:

Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BALANCING LIFE NATURALLY



AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON ARRIVAL OF PARENT OR GUARDIAN). PARENT/GUARDIAN SIGNATURE(S)

DATE: _____

Name of person responsible for payment _____

Do you have insurance coverage? Yes No If yes, which company? _____

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The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Name

SS#

Signature

Date

Parent/Guardian/Spouse Signature Authorizing Care

Date

How did you hear about us? _____

This is to certify that Ten Lakes Chiropractic Clinic has my permission to take X-rays. INITIALS _____

Female Patients: This is to certify that to the best of my knowledge I am NOT pregnant. INITIALS _____
 Date of onset of last menstrual period _____

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