File Number: ______________

Name: ____

Home Phone: ________________________________ Work Phone: _____________________________

Cell Phone: __________________________________ Email Address: ___________________________

Home Address: _______________________________ City: _____________________________________

State: _______________________________________ Zip Code:_________________________________

Social Security #:______________________________ Date of Birth: _____________________________

Occupation: ____

Spouse's Name: _____________________________ Work Phone: _______________________________

Nearest relative not living with you:

____ Phone: __________________________________

Nearest friend not living with you:

____ Phone: __________________________________

Physician: ___________________________________ Phone: __________________________________

Whom may we contact in case of an emergency?

____ Phone: __________________________________

How did you find out about our office and whom may we thank for referring you to us?

____ Phone: __________________________________

Who is responsible for this bill?

____

Terms of Acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:
TO LOCATE, ANALYZE, CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference) prevents the body from functioning at its optimal level. Correcting the subluxations, allows the inborn healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

We do not diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).

I __________________, having read the above statement, and understanding it fully, do undertake Gonstead chiropractic health care on the basis.

Date _________________ Signature____

If patient is a minor:

I authorize the doctors at Venn Chiropractic & Wellness Center to care for my child. I have read and understand the terms of acceptance and agree to them.

Parent or Legal Guardian Name: ____

Signature: ___________________________________ Date: _________________________

Health Insurance Information

Provider: _________________________ Company: ____________________________

Group #: _________________________ Insured Name: _________________________

Insured DOB: _____________________ CoPay Amount: ________________________

I understand that I am personally responsible for all fees and charges. I understand that payment is due AT THE TIME SERVICES ARE RENDERED. I understand that any third party payer may choose not to reimburse me for the cost of any health care procedure. I understand that if my third party payer chooses not to reimburse me for any reason, including but not limited to a deductible not being met, I am personally responsible for all fees and charges. I understand that a $25 charge will be applied to all returned checks. I understand that any reconciliation or adaptation of fees are at the discretion of the Chiropractor, and is to be kept confidential between the chiropractor and myself. I agree to receive important information regarding my chiropractic care via email, phone, or mail.
Print Name: _________________________________
Signature: ___________________________________ Date: ___________________________

Consultation History

Your main complaint: ____

Any other complaints: ____
____
____

How long have you suffered with this problem? ____

What have you tried to get rid of this problem that **DID NOT** work? _______________________________
____
____
____

Have you become discouraged about handling this problem? _____________________________________

When your problem is at its worst, how does it make you feel? ___________________________________
____
____

How does this problem interfere with the following areas of your life? ____________________________

WORK: ____

FAMILY: ____

HOBBIES: ____

LIFE: ____

Does handling this problem cause stress for you? ____

What do you do that makes this problem worse? ____

How much older does this make you feel? ____

On a scale of 1 to 10, with 10 being highest, rate your commitment in helping us solve this problem: _______________

What gives you some temporary relief? ____

What is the pattern of this problem? Constant Intermittent Occasional Cyclic

What is the effect it has on your body function? ____

How did it start? ____

Are you on any medications? __________________ Please list all: _________________________

____
____

Could your problem have been caused by an injury at work? ______________________________
If yes, please give us the details:

____
____

Have you been involved in an auto accident? _______________ Date of accident: _____________
Have you had any difficulties from this?

____
____
____

Do you have any children? ________________________________

Do they have health problems that you are aware of? ____________________________________

If there any other information you would like us to know?
____
____
____

Signature: ___________________________________ Date: _________________________________

For Women Only

Date of your last menstrual period? _ _/_ _/_ _ _ _

Are you using any means of contraception? Yes No

Do you experience severe cramping with your menstrual period? Yes No

Do you suffer from PMS? Yes No

ALLERGIES

Description	Date Detected

CURRENT MEDICATIONS

PRE-EXISTING CONDITIONS LIST

(Please check all that apply)

o Alcohol/drug addiction	o Anemia	o Arrhythmia	o Arthritis
o Asthma	o Bleeding Disorder	o Blood Clots	o Blood Transfusions
o Bowel Problems	o Broken Bones	o Cancer	o Cataracts
o Chicken Pox	o Colitis	o Collagen Vascular Disease	o Depression/Anxiety
o Diabetes	o Eating Disorder	o Emphysema	o Epilepsy
o Gall Bladder Disease	o Genital Herpes	o Glaucoma	o Gout
o Headaches	o Heart Disease/Attacks	o Heart Murmur	o Hemorrhoids
o Hepatitis	o High/Low Blood Pressure	o High Cholesterol	o HIV/AIDS
Joint/Back Pain	o Kidney Infection	o Kidney Stones	o Liver Disease/ Problems
o Lung Disease	o Mental Disorder	o Osteoporosis	o Paralysis
o Pneumonia	o Polio	o Prostate Problems	o Reflux/Ulcers
o Rheumatic Fever	o Seizures	o Sexual Dysfunction	o Sickle Cell
o Stroke	o Suicidal Tendencies	o Thyroid Disease	o Tuberculosis
o Urine Discoloration			

Medical History

Family

	#	Back	Heart	Stroke	Cancer	Diabetes	High BP
Mother							
Father							
No. Sisters							
No. Brothers							
No. Children							

Social

	Daily	3x/wk	2x/wk	1x/wk	2x/mo	1x/mo	Never
Tobacco/Smoke							
Exercise							
Work on Computer							
Sit at a desk							
Work on the phone							
Alcoholic beverages							
Moderate/Heavy labor							
Stay at home							
Deliver Packages							

Surgical

Surgery	Date of Performance