

WELCOME TO ROSELLE CENTER FOR HEALING

Today's Date _____

Please Print:

PERSONAL INFORMATION

NAME: _____ SOCIAL SECURITY: _____ PHONE: _____
MOBILE NUMBER: _____ EMAIL ADDRESS: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
AGE: _____ DATE OF BIRTH: _____ SEX: M / F MARITAL STATUS: _____ CHILDREN? _____
OCCUPATION: _____ EMPLOYER: _____
ADDRESS: _____ WORK NUMBER: _____
NAME OF SPOUSE: _____ OCCUPATION: _____ WORK NUMBER: _____
EMERGENCY CONTACT: _____ PHONE NUMBER: _____
HOW DID YOU HEAR ABOUT US? _____ (Please write in name of person or event)

HEALTH HISTORY

PURPOSE OF THIS APPOINTMENT: _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES _____ NO _____ COMES AND GOES _____
HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? _____
WHAT DO YOU BELIEVE IS WRONG WITH YOU? _____

WHAT POSITIONS OR ACTIVITIES AFFECT YOUR CONDITION? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____
DO YOU TAKE ANY VITAMINS? YES ___ NO ___ DO YOU THINK YOU MIGHT NEED VITAMINS OR MINERALS? YES ___ NO ___
ARE YOU WEARING HEEL LIFTS? ____, SOLE LIFTS ___ INNER SOLES ___ OR ARCH SUPPORTS ___
DO YOU HAVE TINGLING OR NUMBNESS IN : SHOULDERS ___ ARMS ___ ELBOWS ___ HANDS ___ HIPS ___ LEGS ___ KNEES ___ FEET ___
HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR? YES ___ NO ___ DESCRIBE _____

SERIOUS ILLNESS? _____
WHAT OPERATIONS HAVE YOU HAD? _____
DATE OF LAST PHYSICAL: _____ FEMALE: ARE YOU PREGNANT YES ___ NO ___
WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? (Including birth control pills) _____
DATE OF LAST SPINAL X-RAY: _____
HAVE YOU EVER BEEN UNDER CHIROPRACTIC/ ACUPUNCTURE CARE? YES ___ NO ___ DOCTOR'S NAME: _____
ADDITIONAL INFORMATION YOU WOULD LIKE TO TELL US: _____

PLEASE PRINT:

Shoe Size: _____ Width: _____

HAVE YOU EVER SUFFERED FROM: (#1 Constant) (#2 Often) (#3 Seldom)

<input type="checkbox"/> Allergies <input type="checkbox"/> Dizziness <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Ulcers <input type="checkbox"/> Nervousness <input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Foot Trouble <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Kidney Infections <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate Trouble <input type="checkbox"/> Cramps or Backache	<input type="checkbox"/> Excessive menstrual flow <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Depression <input type="checkbox"/> Numbness <input type="checkbox"/> Polio <input type="checkbox"/> Sciatica <input type="checkbox"/> Spinal Curvature <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficult Digestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Immune Deficiency Syndrome	<input type="checkbox"/> Deafness <input type="checkbox"/> Ear Noises <input type="checkbox"/> Thyroid <input type="checkbox"/> Eye Pain <input type="checkbox"/> Failing Vision <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Lumps in Breast <input type="checkbox"/> Alcoholism <input type="checkbox"/> Nausea <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hay Fever <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Asthma <input type="checkbox"/> Colds	<input type="checkbox"/> Sinus Infections <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Pain Over Heart <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Slow Heart Beat <input type="checkbox"/> Anemia <input type="checkbox"/> Stroke <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficult Breathing <input type="checkbox"/> Pleurisy <input type="checkbox"/> Spitting <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes
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CHECK OFF

HABITS	HEAVY	MODERATE	LIGHT	NONE	HABITS	HEAVY	MODERATE	LIGHT	NONE
Dairy					Appetite				
Alcohol					Sodas				
Drugs					Tea				
Exercise					Sweets				
Coffee					Water				
Sleep					Tobacco				

BILLING INFORMATION

IS THIS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF YOUR EMPLOYMENT? YES ___ NO ___

DATE SYMPTOM APPEARED OR ACCIDENT HAPPENED: _____ SAME OR SIMILAR CONDITION? YES ___ NO ___

HAVE YOU LOST ANY DAYS FROM WORK? YES ___ NO ___

NAME OF HEALTH INSURANCE: _____ PHONE#: _____

PAYMENT IS EXPECTED IN FULL AT TIME OF VISIT:

NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare some reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand agree **that all services rendered me are charged directly to me and that I am personally responsible for payment.** I also understand that balances that are 90 days or older will accumulate 9.5% interest. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I further understand that if I fail to pay this bill and it is turned over to an attorney or (collection agency) for collections that I will be responsible for all legal fees, court fees and collection agency fees.

PATIENTS SIGNATURE: _____ DATE: _____

PARENT OR GUARDIAN AUTHORIZING CARE: _____ DATE: _____

Information taken by: _____ Date: _____