

WELCOME TO ROSELLE ALTERNATIVE CARE CENTER

Please Print

Today's Date _____

PERSONAL INFORMATION

NAME: _____ SOCIAL SECURITY: _____ PHONE: _____

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: _____

PATIENTS NEAREST RELATIVE: _____ 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 ___ H IPS ___ LEGS ___ KNEES ___ FEET ___

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR? YES ___ NO ___ DESCRIBE _____

SERIOUS ILLNESS? _____

WHAT OPOPERATIONS 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:

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

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

CHECK OFF

HABBIT	HEAVY	MODERATE	LIGHT	NONE	HABIT	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 I myself. Furthermore, I understand that this office will prepare 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: _____