Bloink Chiropractic
Welcome

Today's Date: _____ File No. _____

Patient's Name _____ Preferred Name _____

Birth Date _____ Age _____ □ Male □ Female SS# _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Phone to be called: □ Home □ Work □ Cell Email address _____

□ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name_____ Children? □ Yes □ No How many? _____

Referred by: _____

Employer _____ How Long? _____

Employer Address _____ City/State/Zip _____

Occupation _____

Primary Insurance Co. _____

Address _____ City/State/Zip _____

Insurance Phone No. _____

Policy No. _____ Group No. _____

Name of Insured _____ Relation _____

Date of Birth _____ Insured's Employer _____

Secondary Insurance Co. _____

Address _____ City/State/Zip _____

Insurance Phone No. _____

Policy No. _____ Group No. _____

Name of Insured _____ Relation _____

Date of Birth _____ Insured's Employer _____

In the event of an emergency, contact _____ Relation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Physician _____ Phone _____

Person responsible for account: _____ Relation _____

Address _____ City/State/Zip _____

SSN _____ DL # _____ Work Phone _____

Payment method: □ Cash □ Check □ Credit Card

_____ I authorize assignment of my insurance rights and benefits directly to Bloink Chiropractic for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

Patient Name _____

Weight _____ Height _____

What is your reason for visiting us today? _____

_____

Please describe the pain and location? _____

_____

When did it begin? _____ Is it □ Better □ Worse □ Comes and goes □ Constant

Is this condition interfering with your □ Work □ Sleep □ Daily routine

If so, please explain _____

Have you had this or similar conditions in the past? □ Yes □ No

If yes, please explain _____

Have you been treated by a medical physician for this condition? □ Yes □ No

If so, where? _____

Have you been treated by a Chiropractor before? □ Yes □ No

If so, whom? _____ Phone No. _____

Are you taking any of the following medications?

□ Nerve pills □ Muscle relaxer □ Stimulants □ Pain killer (including aspirin
□ Blood thinner □ Tranquilizer □ Insulin □ Other _____

Do you have or ever had any of the following diseases or conditions?

□ Heart Attack/Stroke □ Heart Surg/Pacemaker □ Heart Murmur □ Congenital Heart Defect
□ Mitral Valve Prolapse □ Artificial Valves □ Alcohol/Drug Abuse □ Venereal Disease
□ Hepatitis □ HIV+/Aids □ Shingles □ Cancer
□ Frequent Neck Pain □ Emphysema/Glaucoma □ Anemia □ High/Low Blood Pressure
□ Psychiatric Problems □ Rheumatic Fever □ Kidney Problems □ Sever/Frequent Headaches
□ Ulcers/Colitis □ Fainting/Seizures/Epilepsy □ Sinus Problems □ Asthma
□ Diabetes/Tuberculosis □ Difficulty Breathing □ Chemotherapy □ Lower Back Problems
□ Artificial Bones/Jones □ Arthritis

List any allergies _____

List any surgeries/treatments with dates _____

List any **past** serious accidents with dates _____

Family health history _____

Do you take supplements or vitamins □ Yes □ No Exercise? □ Yes □ No

Are you on a special diet? □ Yes □ No Since (date) _____

Do you smoke? □ Yes □ No If yes, how much? _____ How long? _____

Are you wearing □ Heel lifts □ Sole lifts □ Inner soles □ Arch supports

What is the age of your mattress? _____ Is it comfortable? □ Yes □ No

For women: Are you taking birth control? □ Yes □ No

Are you pregnant? □ No □ Yes/How long? _____ Nursing? □ Yes □ No

Please tell us where your injury or discomfort is located. Please mark all areas with the appropriate letter and/or degree of pain. Please use the following abbreviations:

Numbness	NNNN
Pins and Needles	PPPP
Burning	BBBB
Aching	AAAA
Stabbing	SSSS

Indicate on a scale of 1 (discomfort) to 10 (extreme pain)