Welcome to Fall Creek Chiropractic!

We are happy you have chosen us for your health care needs. To serve you as completely as possible, we ask that you complete the following patient information. With this information we will know more about you as a patient, and we will have the ability to file insurance for you, if it is needed. Thanks for your time and patience in providing this information to us – we realize that you are here because you want to feel better, not because you want to fill out paperwork. We want to help you reach your health care goals, so please be complete with your answers.

– thank you!

Patient Information

Date ________________

Patient ____

Last First Initial

Address ____

____

City State Zip

Sex: M F Age ______ Date of Birth ____________

Single Married Divorced Separated Widowed

Patient SS# ________________________________

Occupation ________________________________

Employer ________________________________

Employer Address ____________________________

Employer Phone _____________________________

Spouse's Name ______________________________

Date of Birth ________________ SS# ______________

Occupation ________________________________

Spouse's Employer ____________________________

Provide the name/ location of your primary care physician:

____

Contact Information

Home # _______________ Work # _________________

Cell # _______________ Email ___________________

Best place / time to reach you ______________________

IN CASE OF EMERGENCY, CONTACT:

Name ___________________ Relationship ___________

Best # to call ___________________________________

Insurance Information

Who is responsible for this account? _________________

Relationship to patient (self,spouse,etc.) ______________

Insurance Co. ____________________________________

Group # ____

Subscriber's Name _________________________________

Date of Birth ____________ SS# ___________________

Is the patient covered by additional insurance Yes No

Relationship to patient ____________________________

Insurance Co. ____________________________________

Group # ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _______________ and assign directly to Dr. Wiggers all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____________________________

Accident Information

Is condition due to an accident? Yes No Date ______

Type of accident: Auto Work Other ____________

If Work Comp: Claim # _______ Date of accident: _____

Insurance Co. Name: ______________________________

Adjuster: __________________ Phone: ______________

If auto: Has fault been established? Yours Other

If accident is your fault, please fill out Your Auto Insurance Section; if not, please fill out At Fault Driver's Insurance Section.

Your Auto Insurance Company: ____________________

Adjuster: _________________ Phone: ______________

Claim #: ____

At Fault Driver's Insurance Company: ______________

____

Adjuster: _________________ Phone: ______________

Policy Holder: _________________ Claim #: __________

If you have an attorney, may we contact him/her regarding your care and payment? Yes No

Name ____________________ Phone: ______________

Patient Condition

Reason for Visit ____

When did your symptoms begin? ________________________ How often do you have this pain? ______________

Is it constant or does it come & go? ______________ Is this condition getting progressively worse? Yes No

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _______

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other ________

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

Mark an X on the picture where you continue to have pain, numbness, or tingling

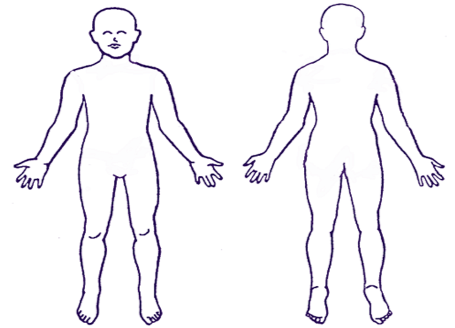
Health History

Have you ever seen a Chiropractor before? Yes No

What treatment have you already received for your condition?
Medications Surgery Physical Therapy None Other __________

Name of other doctor(s) who have treated you for this condition ___________
Date of 1st treatment ________ Spinal x-ray ________ MRI ____________

Please check symptoms you currently have: Headaches Vertigo Nausea
Depression Balance Impairment Loss of Memory Burning Eyes
Lightheadedness Visual/Sensory Disturbance Ringing/Buzzing in Ears



Place an 'X' to note your complaint(s)

Please check conditions or symptoms you currently have or have had in the past:

AIDS/HIV	Cataracts	Herniated Disk	Parkinson's Disease	Tuberculosis
Anemia	Chemical Dep.	Herpes	Pinched Nerve	Tumors
Anorexia	Diabetes	High Blood Pressure	Pneumonia	Ulcers
Appendicitis	Emphysema	High Cholesterol	Polio	Varicose Veins
Arthritis	Epilepsy	Jaw Pain/ TMJ	Prosthesis	Whiplash
Asthma	Glaucoma	Kidney Disease	Psychiatric Care	Other ___________
Blood Clots	Goiter	Liver Disease	Rheumatoid Arthritis	_______________
Breast Lump	Gout	Mononucleosis	Rheumatic Fever	_______________
Bronchitis	Heart Disease	Multiple Sclerosis	Scarlet Fever	_______________
Bulimia	Hepatitis	Osteoporosis	Stroke	_______________
Cancer	Hernia	Pacemaker	Thyroid Problems	_______________

Exercise: None Daily Moderate Heavy **Work Activity:** Sitting Standing Light Labor Heavy Labor
Lifestyle: Smoking; Packs/Day ___ Alcohol; Drinks/Week ____ Coffee/Caffeine; Cups/Day High Stress Why?_____

Are you pregnant? Yes No Due Date ___________________

Injuries/Surgeries you have had

Accidents/Falls ______________________________________ Date ____________________
Head Injuries ______________________________________ Date ____________________
Broken Bones ______________________________________ Date ____________________
Dislocations ______________________________________ Date ____________________
Surgeries ______________________________________ Date ____________________

Medications	Allergies	Vitamins/Supplements
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________