

BELCHER CHIROPRACTIC CENTER – Practice Member Application

Name _____ Date _____ ID _____

Address _____ City _____ State ____ Zip _____

Home Phone () _____ E-mail _____

Work Phone () _____ Cell/Pager () _____

Please circle primary phone: Home Work Cell

Date of Birth _____ Age ____ Sex: M F Marital Status: S M D W

SS# ____ - ____ - ____ Occupation/Employer _____

____ Full Time ____ Part Time ____ Retired ____ Student

Name of Insured _____ Insured's Birthdate: _____

Relationship to patient: _____ Insured's SS# ____ - ____ - ____

Who referred you to our office? _____

Family Dr. _____ Address: _____

Reason for consulting our office:

- ____ Relief of Symptoms
- ____ Correction of a Problem
- ____ Wellness care for optimizing your personal or family's health
- ____ Auto Injury ____ Work Related Date: _____ Reported Y N

Health Concern	What have you tried to solve this problem?

Have you ever been to a Chiropractor? Y N
 If yes, what type of care did you receive? (Relief / Correction / Wellness)
 Are you pregnant? Y N Not Sure

Please circle any below that are a part of your health picture (past or present):

Cancer	Muscular Dystrophy	Convulsions	Digestive Disorder
Polio	Multiple Sclerosis	Epilepsy	Sinus Problems
Tuberculosis	Cerebral Palsy	HIV Positive	Loss of Smell
High B. P.	ALS	Arthritis	Heartburn
Heart Trouble	Concussion	Numbness	Asthma
Diabetes	Headaches	Sleeping Problems	Infertility
Hepatitis	Dizziness	Menstrual Pain	Cold Sweats
Nervousness	Loss of Balance	Menstrual Irregularity	Depression
Irritability	Buzzing in ears	Hot Flashes	Fainting
Fatigue	Backaches	Mood Swings	Problem Urinating

What are your health goals & expectations? _____

When was the last time you felt your best? (How long ago?) _____

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

• **List all operations and their date:**

1. _____ 2. _____ 3. _____

• **List all medications you are currently on and what they are for:**

1. _____ 2. _____
3. _____ 4. _____

• **List any significant physical traumas from birth to the present:**

1. _____ 2. _____
3. _____ 4. _____

• **List any significant emotional traumas since birth:**

1. _____ 2. _____
2. _____ 4. _____

• **How stressful is your life?** Occupation _____ Personal _____

(1 = No stress / 10 = Extreme stress)

What do you feel is your primary stress? _____

Family Health Profile: At our office we are not only interested in your health and well being, but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your loved ones:

Name	Age	Concern
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

If you have insurance:

Are your problems due to an injury? Y N Auto____ On the job____

Insured's name _____ Date of birth _____

Insurance company name _____

Ins. co. address _____

ID # _____ Group # _____

I understand that insurance is an agreement between the insurance company & myself and that billing is done as a courtesy and is not a guarantee of payment. I agree to aid in timely collection from my insurance and I understand that I am ultimately responsible for any unpaid balance on my account. I authorize Belcher Chiropractic Center to administer care as deemed necessary and to release information acquired in the course of my examination or care. I certify that all information on this form is true and correct.

Patient's Signature _____ Date _____