

**CONFIDENTIAL PATIENT INFORMATION**  
**NUTRITION**

Date \_\_\_\_\_

Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital: M S W D How many children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**YOUR EMAIL ADDRESS:** \_\_\_\_\_ @ \_\_\_\_\_

Name of Wife/Husband \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Patient's Nearest Relative (son/daughter) \_\_\_\_\_ Phone Number \_\_\_\_\_

**Referred to our office by** \_\_\_\_\_

**Primary Physician's Name** \_\_\_\_\_ **Address** \_\_\_\_\_

**\*\* Do you smoke:** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Previously** \_\_\_\_\_ **How long ago did you stop smoking?** \_\_\_\_\_

Is your present condition due to your employment? \_\_\_\_\_

Have you ever had a similar condition? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Have you lost any days from work? \_\_\_\_\_ Female: Are you pregnant? \_\_\_\_\_

What operations have you had? \_\_\_\_\_ Serious illnesses \_\_\_\_\_

Have you been under Chiropractic care in the past? \_\_\_\_\_ Name of Doctor \_\_\_\_\_

**\*\* GOAL OF TODAY'S VISIT: (Check all that apply:)**

\_\_\_\_\_ **Weight Loss:** \_\_\_\_\_ **Blood Sugar (Glycemic) Control:** \_\_\_\_\_ **Lower Cholesterol**

\_\_\_\_\_ **Standard Process Supplement Advice and Recommendations** \_\_\_\_\_ **Healthy Living Tips**

\_\_\_\_\_ **Fatigue:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**\*\* MEDICAL HISTORY (Check all that apply:)**

\_\_\_\_\_ **Diabetes/ Pre-Diabetes** \_\_\_\_\_ **COPD** \_\_\_\_\_ **High Cholesterol**

\_\_\_\_\_ **High Blood Pressure** \_\_\_\_\_ **Cancer (\_\_\_\_\_)** \_\_\_\_\_ **Heart Disease**

\_\_\_\_\_ **Kidney Disease** \_\_\_\_\_ **Other** \_\_\_\_\_

**\*\* FAMILY HISTORY for the above listed conditions. Please describe:** \_\_\_\_\_

**\*\* What medications or supplements are you currently taking?** \_\_\_\_\_

**Who prescribed these medicines?** \_\_\_\_\_

**\*\* Allergies:** \_\_\_\_\_

**\*\* Height:** \_\_\_\_\_ **Current Weight:** \_\_\_\_\_ **Goal Weight:** \_\_\_\_\_ **Blood Pressure:** \_\_\_\_\_ / \_\_\_\_\_

**Is there anything else regarding your diet or medical history you would like to share?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE TURN THIS SHEET OVER**

Is your condition getting progressively worse?      Yes      No      Constant      Comes and Goes

Is your condition interfering with your:      Employment      Sleep      Daily Routine      Other \_\_\_\_\_

How long has it been since you felt really well? \_\_\_\_\_

Other Doctors you have seen for your condition: \_\_\_\_\_

Have you been treated for any condition in the past year? \_\_\_\_\_

Describe the condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT**

HOW WILL YOU BE PAYING FOR TODAY'S VISIT?      \_\_\_\_\_ CASH      \_\_\_\_\_ CREDIT CARD      \_\_\_\_\_ CHECK

\_\_\_\_\_ INSURANCE      Are you insured?      \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

**I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making the collections from the insurance company and that any amount authorized is to be paid directly to Incledon Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. SHOULD I BE REIMBURSED DIRECTLY FROM MY INSURANCE COMPANY, I AGREE TO PRESENT THE EXPLANATION OF BENEFITS AND CHECK TO INCLEDON CHIROPRACTIC UPON RECEIPT.**

PATIENT'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

GUARDIAN'S OR SPOUSE'S SIGNATURE AUTHORIZING CARE \_\_\_\_\_ Date \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_