Chiropractic Associates, Inc.

Harold W. Gunn,Jr.,D.C.

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns do not hesitate to ask. Please print legibly.

Name _____ Date of Birth ____/____/_____ Date ____/____/_____
First Middle Initial Last

Address _____ _____ _____ _____
City State Zip

Sex: ☐ Male ☐ Female Height _____ Weight _____ Email address _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Should we need to call you do you prefer to receive calls at: ☐ Home ☐ Cell ☐ Work ☐ No preference

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City, State Zip _____

Spouse or parent's name _____ Employer _____ Phone (____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (____) _____

Symptoms

Reason for visit _____ Date of onset ____/____/_____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Rate the severity of your pain: 1-mild pain or discomfort to 10-severe pain 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment, if any, have you already received for your condition? ☐ M.D ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____

Name of other doctor(s) who have treated you for this condition _____

Health History (*Check only those conditions which apply to you)*

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's disease	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arth.	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	_____
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Stroke	_____

Women: Are you pregnant? **Yes No** ***Nursing*** **Yes No** ***Taking Birth Control*** **Yes No**

List date & type of surgeries you've had. _____

Medications/mgs per dose _____

Allergies _____

Smoking Status I have never smoked I used to smoke but I quit _____ I smoke ____ packs per day for ____

Responsible Party

Name of person responsible for this account (if other than patient) _____

Relationship to patient _____Phone (_____)_____

Address _____City, State Zip _____

Name of employer _____Work Phone (_____)_____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate of insured ____/____/___ Name of employer _____how long _____

Address_____City, State Zip _____Phone (____)_____

Insurance Company _____ID # _____ Group # _____

Claims address _____ City, State Zip _____Phone (____)_____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? __

DO YOU HAVE ADDITIONAL INSURANCE ☐ Yes ☐ No IF YES COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate of insured __/__/___Name of employer _____how long _____

Address_____City, State Zip _____Phone (____)_____

Insurance Company _____ID # _____ Group # _____

Claims address _____ City, State Zip _____Phone (____)_____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? ____

Warning: there is a slight risk of an adverse reaction to a chiropractic adjustment. If you have any questions or concerns please feel free to ask. Initial to acknowledge that you have read and understand this statement __

Certification and Assignment

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility To inform my doctor if I/or my minor child, ever have a change in health.

I certify that I, and/or my dependant(s) have insurance coverage with _____ and assign directly to Chiropractic Associates, Inc. all insurance benefits payable, if any, for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges not paid by insurance. I agree to pay all attorney fees, court costs and/or collection costs if professional collection services and/or legal action are required against me.

The above named clinic may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining benefits payable for services.

_____ ____/____/_____

Signature of patient, parent, guardian or personal representative Date

_____ ____/____/_____

Please print name of patient, parent, guardian or personal representative Date