



PATIENT INFORMATION FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Social Security Number [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Mother: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Guardian / Foster Parent: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Who do you normally live with (check all that apply)? [ ] Father [ ] Mother [ ] Guardian / Foster Parent [ ] None of These

Marital Status: [ ] Married [ ] Separated [ ] Widowed [ ] Single How many children? \_\_\_\_\_

CURRENT ADDRESS OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home)

Street \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

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

Work Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Student at \_\_\_\_\_ [ ] FULL-TIME [ ] PART-TIME

Who should we contact in the event of an emergency? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address of contact person \_\_\_\_\_

Who may we thank for the referral or how did you learn about us? \_\_\_\_\_

Is your condition or injury due to an accident or work-related cause? [ ] YES [ ] NO Please check ALL that apply.

Did the condition or injury result from automobile accident? [ ] YES [ ] NO

Did it result from a work-related accident or cause? [ ] YES [ ] NO (briefly describe): \_\_\_\_\_

Approximately, when did your injury or condition occur? \_\_\_/\_\_\_/\_\_\_

Primary Care Physician: \_\_\_\_\_ May we contact your doctor regarding your condition? [ ] YES [ ] NO

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ Date of Last Visit: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ Date of Last Visit: \_\_\_/\_\_\_/\_\_\_

Financial Responsibility

Who is financially responsible for your care: [ ] Health Insurance [ ] Auto Insurance [ ] Worker's Compensation [ ] Self

If this is through your health insurance: List Company: \_\_\_\_\_

Full Name of Policy Holder: \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_/\_\_\_/\_\_\_ Does the policy holder have the insurance through his/her employer? [ ] YES [ ] NO If yes, who is the employer? \_\_\_\_\_

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

# Fisher Chiropractic & Integrative Health

## Health Insurance Election

(Accident and Non-Accident Cases)

How would you like for us to handle your health insurance? Please choose one:

**Option 1 -- I Want You to File My Health Insurance and Also to Help Me Verify My Benefits. To Help You Get Paid, I'll Make Partial Payments and/or Sign an Assignment & Financial Policy**

*I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment even if this is an accident case. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now or later for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. If my condition is due to an accident case, I would ask that you delay from collecting such amounts as described in your Financial Policy. With this in mind, I agree to the terms of the Financial Policy. In the event that my health insurance delays or Denies Payment, I will be responsible for payment as described in the Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.*

**Option 2 -- I Do Not Have Health Insurance / I Don't Want You to File My Health Insurance**

*I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may keep any health insurance, which I do have, on file as set forth in your Financial Policy. You may ask to be paid now or later as I am responsible for payment. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.*

**Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund**

*I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.*

**Important:** I understand that in certain circumstances, the Office may have a policy of not filing health insurance or law may actually control or regulate the filing of insurance. This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Patient Name: \_\_\_\_\_



Pediatric Intake Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Female / Male

Most Important Health Concerns: \_\_\_\_\_ How Long? \_\_\_\_\_

- 1) \_\_\_\_\_
2) \_\_\_\_\_
3) \_\_\_\_\_
4) \_\_\_\_\_

Medications (please circle)

- Aspirin Decongestants Antibiotics
Tylenol Anti-Histamine Ibuprofen

Other: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Medical History (please circle)

- Chicken Pox Scarlet Fever Tonsillitis Frequent Colds Mumps
Measles Pneumonia Ear infections Rheumatic fever Rubella
Mumps Rubella Strep throat Other: \_\_\_\_\_

Family History: Is there a family history of any of the following? (please circle)

- Heart disease Diabetes Birth Defects Allergies
Hypertension Arthritis Tuberculosis Asthma
Mental Illness Osteoporosis Cancer Other: \_\_\_\_\_

## Immunizations

MMR     DPT     Chicken Pox     Small Pox  
 Measles     Diphtheria     H. Influenza     Hepatitis b  
 Mumps     Tetanus     Rubella     Polio  
Others: \_\_\_\_\_ Adverse Reactions: Yes / No

Has your child ever had any of the following? If so, when and what results?

Previous Chiropractic Care: \_\_\_\_\_

Psychological Evaluations: \_\_\_\_\_

Hearing test: \_\_\_\_\_

Speech/Language Tests: \_\_\_\_\_

Injuries/Surgeries/Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Prenatal History

Mother's age at child's birth: \_\_\_\_\_

Mother's health during pregnancy:

Bleeding     Nausea     Physical or emotional trauma  
 Illnesses     Hypertension     Cigarettes, alcohol, drug consumption  
 Medications     Diabetes     Thyroid problems

## Birth History

Term: Full / Premature / Late    Length of labor: \_\_\_\_\_

Were there any complications? \_\_\_\_\_

Did your child have any of the following problems shortly after birth?

Rashes    Birth Injuries    Blue Baby    Colic    Birth defects  
Jaundice    Seizures    Cerebral Palsy    Fever  
Other: \_\_\_\_\_

Breast fed: y / n      How long? \_\_\_\_\_      Formula: y / n      Type: milk / soy / other

Age began solid foods: \_\_\_\_\_

Age began:    Sitting \_\_\_\_\_      Crawling \_\_\_\_\_      Walking \_\_\_\_\_      Talking \_\_\_\_\_

Has your child experienced any of the following recently: (please circle)

Hives	Burning urine	Bloody urine	Eczema
Bleeding gums	Heart murmur	Nervousness	Hair loss
Nose bleeds	Vomiting spells	Sleep problems	Asthma
Acne	Anemia	Night sweats	High fevers
Jaundice	Sensitivity to light	Chronic rashes	Sore throats
Diarrhea	Hearing loss	Easy bruising	Cough
Flat feet	Loss of appetite	Body/breath odor	Constipation
Allergies	Stomach aches	Unusual fears	Excessive fatigue
Nightmares	Frequent colds	Bleeding tendency	Frequent urination
Wheezing	Joint pains	Dizzy spells	

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Drinks: \_\_\_\_\_

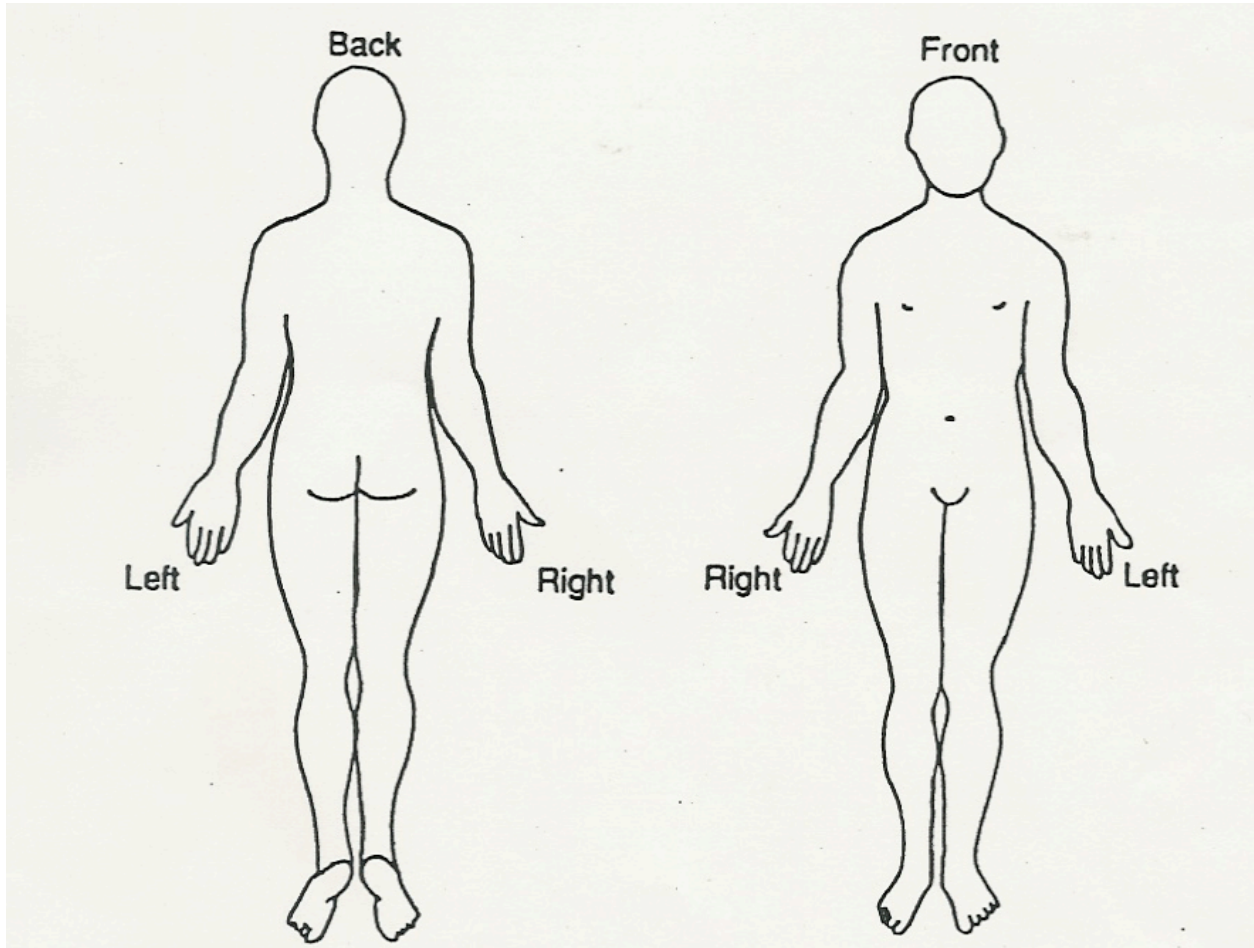
# PAIN DIAGRAM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.**

Ache-A  
Burning-B  
Numbness-N

Pins and Needles-P  
Stabbing-S  
Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling **at this time**.

Date: \_\_\_\_\_

