

Schneider Chiropractic

81 Glen Road, Garner NC 27529 Date: ____/____/____

Confidential Health History

(please print clearly & answer all question, use N/A if not applicable.)

Name _____ Home phone _____ Cell phone _____
 Address _____ City _____ State _____ Zip Code _____
 Age _____ Birthdate ____/____/____ Marital status: M S W D, # of children _____
 Occupation _____ Employer _____ wk phone () _____
 E mail address: _____ Name of Spouse _____ Occupation _____

Emergency contact (name/address/phone) _____

Medical Doctor: name _____ town _____ phone: _____

Present Health Concern: What is the **#1 health concern** that caused you to seek care in our office?

Was is the **cause** of your #1 health concern?: _____

Please indicate any illness, surgery or medications that relate to you.

Have you ever had the following?: (please include dates and/or other details)

ILLNESS: Mono _____ TB _____ Hepatitis: Type() _____
 Meningitis _____ Diabetes _____ Hypoglycemia _____ B/P _____
 Stroke _____
 HIV/Aids _____ Heart: _____ Vascular: _____
 Cholesterol _____ Thyroid _____ Neurological _____
 Cancer _____ Other: _____ **None**

Comments: _____

SURGERY: Tonsils _____ Appendix _____ Gallbladder _____
 Spinal or Joint _____ Hysterectomy _____
 Cosmetic _____ Other: _____
 Hospitalizations _____ **None**

Comments: _____

MEDICATIONS for: Headaches Sinus Diabetes Allergy Asthma Digestive
 Heart Anti-Depressants Nerve Blood Pressure Cholesterol Birth Control
 Sleep Other(including over the counter) **None**

(PLEASE include any additional details on Systems Review Sheet)

Injuries: fractures/broken bones? _____

None

Motor Vehicle Accidents:

Date	Type(Rear Ended, Side Impact, Head on, Rolled/Flipped)	Treatment? (Hospital, P/T, Chiropractic)

*** Please complete this form on back of this page!

Have you ever had **Chiropractic care** before? Y N, **If yes:** with Dr.? _____
Location _____ When? _____ For what problem? Other: _____
or exact same problem Results?: _____
Have you been treated by a Dr. or clinic for any health conditions in the last year? Y N
If yes, what were they? _____

How would you rate your **overall health**? Poor Fair Good Excellent

FOR WOMEN ONLY: The following information is **essential** in order to determine if x-rays can be safely taken & what treatment procedures will assure you the greatest results and safety.-*Thank you!*

Are you **pregnant** at this time? Y N. _____

Are you **trying to become pregnant** at this time? Y N _____

Are you **taking any birth control medication?** Y N Explain? _____

Do you **smoke** at all? Y N If yes... **How much?** _____/day

***Please note:** Our office policy requires that payment be made at the time of your office visit. What **method of payment** will you be using today? Cash Check Credit / Debit card

I hereby authorize Dr. Bruce Schneider or his assistants to examine me and take any x-rays deemed necessary by the Doctor. I authorize treatment for myself and/or my children (if applicable). Schneider Chiropractic has my permission to release to, or obtain my records from... my insurance company, attorney, or any of my doctors, if needed.

*** If I have health insurance for chiropractic services, I will pay any unpaid balance (deductibles, co-insurance, co-payments or fees for services not covered regardless of their reasoning). This applies to automobile and work related injury cases as well. If this office is a participating provider in my health plan, I request that my insurance benefits be assigned to the doctor and agree that any costs of collection incurred on my account are my responsibility. If this office is not a participating provider in my insurance program, I realize that the fee for any and all services are my responsibility and are due at the time the services are rendered. I also agree that any costs of collection incurred on my account are my responsibility.

If I ever request a copy of my x-rays or records, it will be at my expense and will require written notice submitted to this office, pre-paid, one week in advance.

I certify that the above information is accurate and truthful. I understand the policies of this office and present to Dr. Schneider for evaluation and/or treatment of a health related condition and for no other purpose or reason.

*(For our **Spanish speaking patients:** "I, the undersigned, understand that this and all forms I have signed in this office have been translated and/or explained to my satisfaction".

Signature of Patient _____

If patient is a minor, Signature of parent and/or guardian _____

Witness by: _____ **Date:** ____/____/____