WELCOME TO. . .
Columbia Advanced Chiropractic, LLC

www.yourchiropractor.net

Allen Manison, D.C., DACBSP,
CCEP, CSCS

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ABOUT YOU

Today's Date: ____/____/____

Name: _____

What you prefer to be called: _____

Birthdate: ____/____/____ SS#: _____

Home Address: _____

_____

Home Phone: ( ) _____

E-mail: _____

Referred by: _____

Occupation: _____

Employer: _____

Employer's Address: _____

_____

Work Phone: ( ) _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____

two

Cell Phone:

_____

INSURANCE INFO

Co. Name: _____

Address: _____

_____

Phone: ( ) _____

Name of Insured: _____

Policy #: _____

Insured's Birthdate: _____

Relationship: _____

Group #: _____

Insured's Employer: _____

Please inform front desk if there is a secondary insurance.

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ☐Yes ☐No

If so, please explain: _____

_____

The reason for this visit is a result of (please circle): work, sports, auto, trauma, or chronic

Explain what happened: _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? _____

Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes

Is this condition interfering with your (Please circle): Work, Sleep, or Daily routine?

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ☐Yes ☐No

If so, where? _____

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Continued on back

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EMERGENCY CONTACT

Who should we contact? _____

Relationship: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

HEALTH HISTORY

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Are you taking any of the following medications?

☐Nerve pills ☐Pain killers (including aspirin) ☐Muscle relaxers ☐ Insulin
☐Stimulants ☐Tranquilizers ☐Blood Thinners ☐Other(s) _____

Have you ever had any of the following diseases/medical condition(s)?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Low Back Problems	Y N Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical conditions(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any past serious accidents with dates: _____

_____

Do you smoke? ☐No ☐Yes How much? _____ How long? _____

Are you wearing: ☐Heel lifts ☐Sole lifts ☐Inner soles ☐Arch supports

What is the age of your mattress? _____ Is it comfortable? ☐Yes ☐No

For women: Are you taking Birth Control? ☐Yes ☐No

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PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

Phone: ( ) _____

Please Check One:

☐ General Practitioner

☐ Internist

☐ Other _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I understand that 24 hours notice is required to change or cancel an appointment time. Failure to do so can result in a $40 missed appointment fee per appointment slot scheduled. (This fee is my responsibility)

Signature _____ **Date** ____/____/____