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WELCOME TO. . .
Columbia Advanced Chiropractic, LLC

www.yourchiropractor.net
Allen Manison, D.C., DACBSP, CCEP, CSCS
Scott Vanina, D.C., DACBSP, EMT

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: ____________________

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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

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 $50 missed appointment fee per appointment slot scheduled. (This fee is my responsibility)

Signature______________________ **Date** ____/____/____