

**CARLSON CHIROPRACTIC OFFICES**

410 1<sup>st</sup> Avenue West  
Kalispell, MT 59901  
(406) 257-3004

**CONFIDENTIAL PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_ SSN \_\_\_\_\_ HOME PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ MARITAL STATUS: M S W D HOW MANY CHILDREN? \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_

INSURED'S NAME IF PATIENT IS A DEPENDENT \_\_\_\_\_ SSN \_\_\_\_\_

NAME OF HUSBAND OR WIFE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

PATIENTS NEAREST RELATIVE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**REFERRED BY**

IS CONDITION DUE TO INJURY OR SICKNESS ARISING FROM PATIENTS EMPLOYMENT? YES \_\_\_ NO \_\_\_

DATE SYMPTOMS APPEARED OR ACCIDENT HAPPENED \_\_\_\_\_

PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES \_\_\_ NO \_\_\_ IF YES, WHEN AND DESCRIBE \_\_\_\_\_

HAVE YOU LOST ANY DAYS FROM WORK? \_\_\_\_\_

DATE OF LAST PHYSICAL EXAMINATION \_\_\_\_\_ FEMALE: ARE YOU PREGNANT? \_\_\_\_\_

SERIOUS ILLNESS \_\_\_\_\_

• **HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE?** YES \_\_\_ NO \_\_\_ DOCTOR'S NAME \_\_\_\_\_

**PURPOSE OF THIS APPOINTMENT (MAJOR COMPLAINT)**

WHAT AGGRAVATES YOUR CONDITION? \_\_\_\_\_

IS THIS CONDITION GETTING PROGRESSIVLY WORSE? YES \_\_\_ NO \_\_\_ CONSTANT \_\_\_ COMES AND GOES \_\_\_

IS THIS CONDITION INTERFERING WITH YOUR: WORK \_\_\_ SLEEP \_\_\_ DAILY ROUTINE \_\_\_ OTHER \_\_\_

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? \_\_\_\_\_

WHAT DO YOU BELIEVE IS WRONG WITH YOU? \_\_\_\_\_

OTHER DOCTORS SEEN FOR THIS CONDITION? \_\_\_\_\_

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR? YES \_\_\_ NO \_\_\_ DESCRIBE \_\_\_\_\_

WHAT MEDICATIONS ARE YOU TAKING? \_\_\_\_\_

REMARKS AND ADDITIONAL INFORMATION \_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT**

NAME OF PERSON RESPONSIBLE FOR PAYMENT \_\_\_\_\_

ARE YOU INSURED? YES \_\_\_ NO \_\_\_ COMPANY \_\_\_\_\_

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN AGREEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS CHIROPRACTIC OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS CHIROPRACTIC OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I WILL ALSO GIVE THIS OFFICE POWER OF ATTORNEY TO ENDORSE CHECKS MADE OUT TO ME, TO BE CREDITED TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE. AN 18% APR WILL BE ADDED TO BILLS PAST 90 DAYS OLD

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

GUARDIAN OR SPOUSE'S SIGNATURE AUTHORIZING CARE \_\_\_\_\_ DATE \_\_\_\_\_

INFORMATION TAKEN BY \_\_\_\_\_

