Chart #_____

Sikeston Chiropractic Registration and History

Patient Name: _____ DOB: _____ SSN: _____
Last First Middle Initial

Address : _____ Email : _____
Street City State Zip

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Occupation:_____ Employer: _____

O Married Spouse: _____ Spouse Phone: _____

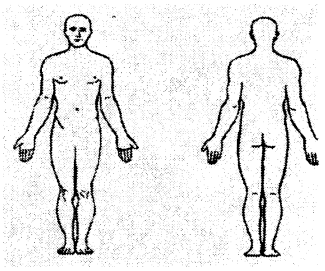
O Single In case of emergency,contact name/number: _____

O Other Who may we thank for referring you to our office? _____

Who is your primary care physician? _____

Have you had chiropractic care in the past? Y / N If yes, who was the chiropractor?_____

Reason for visit: _____
When/How did condition begin? _____
What have you tried to help so far?_____ Did it help? Y/N
What movements/activities make it worse? _____
How would you describe the condition? (circle all that apply)
Sharp Dull Aching Numb Tingling Weakness Cramps Stiff Burning
Does the pain travel down the arms/legs? Y/N
On a scale from 1 to 10, how intense are your symptoms? _____
Has it been getting better, worse, or staying the same? _____
Is it constant, or does it come and go?_____



Indicate location of symptoms on drawing

Y / N	AIDS/HIV	Y / N	Anemia	Y / N	Arthritis	Details/Other: _____
Y / N	Cancer	Y / N	Diabetes	Y / N	Headaches/Migraines	_____
Y / N	Heart Disease	Y / N	Herniated Disc	Y / N	High Blood Pressure	_____
Y / N	Epilepsy	Y / N	High Cholesterol	Y / N	Kidney Disease	_____
Y / N	Liver Disease	Y / N	Osteoporosis	Y / N	Pacemaker	_____
Y / N	Pinched Nerve	Y / N	Stroke	Y / N	Thyroid Issues	_____

Please list any surgeries and the date occurred: _____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

What types of activities/tasks do you regularly perform:

At work: _____

At home: _____

On a scale from 1 to 10, how would you rate your overall stress level? _____

What do you do for exercise, if any? _____

What do you enjoy doing in your free time? _____

What are your goals for treatment at our office? _____

On a scale from 1 to 10, how would you rate your current overall health? _____

SIKESTON CHIROPRACTIC

Brett Taylor, D.C.
1222 Linn Street
Sikeston, MO 63801
(573) 471-4652

Office Policies

- We request payment at time of service unless prior arrangements are made.
- In instances where health insurance or Medicare will be covering a portion of treatment costs, the patient is responsible for paying their share of costs at the time of service (such as deductibles, copays, and/or co-insurance.)
- Any charges denied by health insurance companies or Medicare will become the responsibility of the patient.
- Our office mails billing statements to patients on a monthly basis. These bills are due within 30 days of the date they were mailed. Our office reserves the right to charge a 1.5% late fee on balances more than 30 days delinquent.
- Balances that remain unpaid for longer than 90 days may be turned over to a collection agency. The collection agency's fees will also become the responsibility of the patient.
- If you are unable to keep your scheduled appointment, we request that you call our office 24 hours prior to your appointment time. If we do not hear from you prior to a missed appointment then a $25 fee will be charged.
- If paying by credit/debit card, a 4% convenience fee will be applied. This fee can be avoided by paying with cash or check.
- Our office will not release your personal or health information without your consent. By signing this page, you are granting your consent to release information to your health insurance provider and/or Medicare.

Signature of Patient _____ Date: _____
(or legal guardian)

Printed Name of Patient _____