

Tallmadge Chiropractic - Confidential Member Application

Name _____ Date _____

Sex: M or F / Marital Status: S M D W Date Of Birth _____ Age _____

Home Phone () _____ - _____ e-mail address _____

Work Phone () _____ - _____ Cell Phone () _____ - _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Type of work _____ # of yrs. _____

Spouses First Name _____ # of Children _____

Name of nearest relative _____ Phone # _____

Who referred you to our office? _____

Reason for consulting our office:

- Relief of Symptoms
- Correction of a Problem
- Wellness care for optimizing your personal or family's health

List your health concerns in order of importance:

Health Concern	What have you tried to solve this concern?
1.	
2.	
3.	
4.	

Have you ever been to a Chiropractor? _____

If yes, what type of care did you receive? (Relief / Correction / Wellness)

Please circle any of the following that are part of your health picture (past or present):

Cancer	Muscular Dystrophy	Cerebral Palsy	Digestive Disorders
Polio	Multiple Sclerosis	ALS	Sinus Trouble
Tuberculosis	Convulsions	Nervousness	Backaches
High Blood Pressure	Epilepsy	Asthma	Numbness
Heart Trouble	Concussion	Dizziness	Arthritis
Diabetes	Hepatitis	Infertility	HIV positive
Headaches	Fatigue	Sleeping problems	Cold Sweats
Mood swings	Loss of smell	Buzz/ring in Ears	Depression
Irritability	Problems urinating	Hot Flashes	Heartburn
Menstrual pain	Menstrual irregularity	Loss of Balance	Fainting

What are your health goals & expectations? _____

When was the last time you felt your best? (How long ago?) _____

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

• **List all operations and their date:**

1. _____ 2. _____ 3. _____

• **List all medications you are currently on and what they are for:**

1. _____ 2. _____
3. _____ 4. _____

• **List any significant physical traumas from birth to the present:**

1. _____ 2. _____
3. _____ 4. _____

• **List any significant emotional traumas since birth:**

1. _____ 2. _____
3. _____ 4. _____

• **How stressful is your life?** Occupation _____ Personal _____
(1 = No stress / 10 = Extreme stress)

What do you feel is your primary stress? _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children's Names	Ages
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Children _____
Children _____
Spouse _____
Others _____

If you have insurance: (Please fill out the following)

Insured name _____ DOB _____ ID# _____ Group # _____
Insurance Co. Name _____

Note: It is understood and agreed that the amount paid for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being part of the permanent record and may be seen at any time while a patient at this office. The patient also agrees he/she is responsible for payment for all bills incurred at this office.

VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE. ALL CLAIMS ARE SUBJECT TO INSURANCE REVIEW

Patients or guardian signature _____ Date _____