THE CONNECT
CHIROPRACTIC

1210 6th St. Ste. #103

Nevada, Iowa 50201

ABOUT YOU.

Name _____ Today's Date_____

Birthdate _____ Age_____ Address _____

City _____ State _____ Zip _____Home Phone _____

Cell Phone _____ Work Phone _____ Gender M F

Significant Other's Name _____

Kid's Names and Ages

_____

Your Employer _____ Type of Work _____

E-Mail Address

_____

Have you been to a chiropractor before? ▫ No ▫ Yes

Emergency Contact_____ ph. # _____

Name of Medical Doctor(s)_____

I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child. I authorize The Connect Chiropractic to release and / or request records to or from other providers as may be necessary. I understand I am responsible for all bills incurred in this office. I authorize assignment of my insurance benefits (if applicable) directly to the provider.

Person responsible for this account if other than the patient? _____

I understand that after any initial promotional services all care is rendered at usual and customary fees. For my balance my preferred payment method is:

Cash Check Credit Card Car/Work Ins.

_____

Patient / Parent Signature (This represents a long-term authorization for all occasions of service)

REASON FOR SEEKING CARE.

PRESENT COMPLAINTS

1. _____How long has this been an issue? _____

Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse Mild Moderate Severe Worse in the morning Worse in evening
Pain radiates to_____

2. _____How long has this been an issue? _____ **Is it:** Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to_____

3. _____How long has this been an issue? _____ **Is it:** Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to_____

4. _____How long has this been an issue? _____ **Is it:** Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to_____

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____
_____

9. Type of treatment:_____

10. Results: _____

NOTES:
_____

Are you pregnant? Yes No

Please mark all areas of concern.