Shealer
Chiropractic, P.C.

Name ______________________________ Social Security # ______________

Address ___________________________ City __________ State ___ Zip _____

Home Phone __________________ Birth Date ____/____/____ Age __________

Cell Phone _________________ Marital Status ___ Spouse's Name ___________

Work Phone _____________ Employer _____________ Occupation __________

Work Address _______________________ City ___________ State ___ Zip_____

Email _______________________________

**How did you hear about us?**

___ Referral (who?) ____________________
___ Spinal Screening (where?) ___________
___ Yellow Pages
___ Saw Sign/Knew where we were
___ Google
___ Other Internet Search
___ Insurance Directory
___ Other _____________

**COMPLAINTS**

What is the reason for this appointment? _________________________________

How long have you had this? __________________ Is it getting worse? Yes/No

Is it constant ____ or does it come and go ____?

Have you had a similar condition in the past? Yes/No When? _______________

What have you done for this problem? ____________________________________

______________________________________________________________________

What other health problems do you have? __________________________________

______________________________________________________________________

What medications are you taking? ___________________________________________

Have you had any surgeries? _________________________________________________

Have you ever been diagnosed with cancer? __________________________________

Do you have any allergies? ___________________________________________________

**Your Primary Care Physician's Information**

Name_______________________________________________________________________

Address _______________________________________ City ______________ State _____

Phone Number _______________________ Date of last physical exam _____________

Have you ever been in a work or auto accident?  Yes/No   When? _____________

| | | |
|---|---|---|
| Do you smoke? | Yes___________<br>No ___________ | How Often? ___________ |
| Do you drink alcohol? | Yes___________<br>No ___________ | How Often? ___________ |
| Do you use illicit drugs? | Yes___________<br>No ___________ | How Often? ___________ |

**Do you know what an Advanced Directive is?**

Advanced Directives are a means for you to tell your health care givers about the care you wish to receive or not receive should you ever become unable to tell them of your wishes.  There are two forms of Advanced Directive.  The first is a Living Will.  The other is known as a "durable power of attorney for health care decisions," or may also be called "durable appointment of a surrogate health care decision."  Please discuss your Advanced Directive choices with your Primary Care Physician.

*Any x-rays taken at this office will remain the property of this office.  I authorize Shealer Chiropractic, P.C. to release information to my insurance company for payment.  I authorize release of information to Shealer Chiropractic, P.C. from other facilities regarding treatment.  The above statements are true to the best of my knowledge.*

****Please give the receptionist your Health Insurance card so it can be copied****

***Patient Signature*** ________________________________________ ***Date*** _____________