



Patient Application

Acct # _____

Please complete the application in full and use N/A for anything that does not apply.

Please Print in BLUE or BLACK ink

Full Legal Name _____ Age _____ DOB _____ / _____ / _____

Home Address _____ City _____ State _____ Zip Code _____

Cell Phone () _____ Cell Phone Company for TEXT appt reminders _____

E-Mail Address _____ Social Security # _____

Marital Status S M D W Name of Spouse _____

Names and Ages of Children _____

Occupation _____ Employer _____

Business Address _____ City _____ State _____ Zip _____

Business Phone () _____ May we contact you at work? Yes No

Person to contact in case of emergency _____ Ph # () _____ Relationship _____

How were you or who referred you to our clinic? _____

What are your main concerns to see the doctor today? _____

Have you ever received Chiropractic care? Yes No Chiropractor's name _____

Date of last adjustment _____ / _____ / _____ Reason for ending care _____

Name of current medical doctor _____ Phone () _____

Date of last medical examination _____ / _____ / _____

Which of the Following Most Clearly Describes Your Current Goals for Health

_____ I am concerned with pain relief **only**.

_____ I am concerned with pain relief **AND** learning how to improve my health to prevent future health concerns.
(May include fitness, dietary, sleeping and positive affirmation habit modification)



Financial Information

Acct # _____

Payment in full is required on each visit unless prior arrangements have been made.

Please indicate your preferred method of payment. ___ Cash ___ Check ___ Credit Card

If you have insurance, please indicate the type of policy and name of insurance carrier:

_____ Medical Insurance _____ Auto Accident Med Pay _____ Worker's Comp

Name of Insurance Carrier: _____ Policy # _____

**Please present your insurance card and a photo ID
to our reception desk upon your initial visit.**

Please advise us any time your insurance carrier changes.

FINANCIAL AGREEMENT: I authorize the treating Chiropractor to furnish information concerning my condition and direct any applicable insurer to pay directly to the doctor or clinic any and all benefits due as a result of evaluation and treatment. **I am aware that I am personally responsible for charges and any balance not covered by insurance. I agree to pay any unpaid balance, reasonable attorney fees, costs and expenses, collection and litigation fees, if necessary, to collect any overdue balance.** I hereby state and agree that a photocopy of this document will be valid and binding on all parties involved as the original copy.

INFORMATION CONSENT TO RECEIVE CHIROPRACTIC CARE: I, the undersigned, give the doctor permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis and treatment. Chiropractic care seldom causes any complications, but in rare cases, due to underlying physical defects, deformities or pathologies may render a patient susceptible to injury. The doctor will not provide care if they are aware of any contraindication that may be present. It is the responsibility of the patient to make it known to the doctor or health care provider if they are aware of any underlying deformities or defects that may not otherwise come to the attention of the doctor.

_____ Date ____ / ____ / ____
Signature of Patient

If patient is under the age of 18, signature of your Parent or Guardian _____ Date ____ / ____ / ____
Signature of Parent or Guardian

**Thank you for choosing our doctors.
We look forward to helping you develop optimum health, vitality and wellness!**



Health History Questionnaire

INSTRUCTIONS:

Please circle the most appropriate answer.

Patient Name _____

Date ____ / ____ / ____ Acct # _____ Score _____

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|---|--|-----|----|
| 1 | Do you need glasses to read? | YES | NO |
| 2 | Do you need glasses to see things at a distance? | YES | NO |
| 3 | Has your eyesight often blacked out completely? | YES | NO |
| 4 | Do your eyes continually blink or water? | YES | NO |
| 5 | Do you often have bad pains in your eyes? | YES | NO |
| 6 | Are your eyes often red or inflamed? | YES | NO |
| 7 | Are you hard of hearing? | YES | NO |
| 8 | Have you ever had a draining ear? | YES | NO |
| 9 | Do you have constant noises in your ears? | YES | NO |

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|----|---|-----|----|
| 10 | Do you have to clear your throat frequently? | YES | NO |
| 11 | Do you often feel a choking lump in your throat? | YES | NO |
| 12 | Are you often troubled with bad spells of sneezing? | YES | NO |
| 13 | Is your nose continually stuffed up? | YES | NO |
| 14 | Do you suffer from a constantly running nose? | YES | NO |
| 15 | Have you at times had bad nose bleeds? | YES | NO |
| 16 | Do you often catch severe colds? | YES | NO |
| 17 | Do you frequently suffer from heavy chest colds? | YES | NO |
| 18 | Do you frequently go to bed when you have a cold? | YES | NO |
| 19 | Do frequent colds keep you miserable during the year? | YES | NO |
| 20 | Do you get hay fever? | YES | NO |
| 21 | Do you suffer from asthma? | YES | NO |
| 22 | Are you troubled by constant coughing? | YES | NO |
| 23 | Do you frequently cough up blood? | YES | NO |
| 24 | Do you sometimes have severe soaking sweats at night? | YES | NO |
| 25 | Have you ever had a chronic chest condition? | YES | NO |
| 26 | Have you ever had T.B. (Tuberculosis)? | YES | NO |
| 27 | Did you ever live with anyone who had T.B.? | YES | NO |

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|----|--|-----|----|
| 28 | Has a doctor ever said your blood pressure was too high? | YES | NO |
| 29 | Has a doctor ever said your blood pressure was too low? | YES | NO |
| 30 | Do you have pains in the heart or chest? | YES | NO |
| 31 | Are you often bothered by thumping of the heart? | YES | NO |
| 32 | Do you often have a rapid heart rate? | YES | NO |
| 33 | Do you often have difficulty in breathing? | YES | NO |
| 34 | Do you get out of breath easily? | YES | NO |

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|----|--|-----|----|
| 35 | Do you sometimes get out of breath just sitting still? | YES | NO |
| 36 | Are your ankles often swollen? | YES | NO |
| 37 | Do cold hands or feet trouble you even in hot weather? | YES | NO |
| 38 | Do you suffer from frequent cramps in your legs? | YES | NO |
| 39 | Has a doctor ever said you had heart trouble? | YES | NO |
| 40 | Does heart trouble run in your family? | YES | NO |

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|----|--|-----|----|
| 41 | Have you lost more than half your teeth? | YES | NO |
| 42 | Are you troubled by bleeding gums? | YES | NO |
| 43 | Have you often had severe toothaches? | YES | NO |
| 44 | Is your tongue usually badly coated? | YES | NO |
| 45 | Do you frequently have a poor appetite? | YES | NO |
| 46 | Do you usually eat sweets or other food between meals? | YES | NO |
| 47 | Do you gulp your food in a hurry'? | YES | NO |
| 48 | Do you often suffer from an upset stomach? | YES | NO |
| 49 | Do you usually feel bloated after eating? | YES | NO |
| 50 | Do you usually belch a lot after eating? | YES | NO |
| 51 | Are you often sick to your stomach? | YES | NO |
| 52 | Do you suffer from indigestion? | YES | NO |
| 53 | Do severe pains in the stomach often double you up? | YES | NO |
| 54 | Do you suffer from constant stomach trouble? | YES | NO |
| 55 | Does stomach trouble run in your family? | YES | NO |
| 56 | Has a doctor ever said you had stomach ulcers? | YES | NO |
| 57 | Do you suffer from frequently loose bowel movements? | YES | NO |
| 58 | Have you ever had bloody diarrhea? | YES | NO |
| 59 | Were you ever troubled with intestinal parasites? | YES | NO |
| 60 | Do you frequently suffer from constipation? | YES | NO |
| 61 | Have you ever had hemorrhoids? | YES | NO |
| 62 | Have you ever had jaundice (yellow eyes and skin)? | YES | NO |
| 63 | Have you ever had serious liver or gall bladder trouble? | YES | NO |

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|----|---|-----|----|
| 64 | Are your joints often painfully swollen? | YES | NO |
| 65 | Do your muscles and joints frequently feel stiff? | YES | NO |
| 66 | Do you usually have severe pains in the arms or legs? | YES | NO |
| 67 | Are you debilitated with severe arthritis? | YES | NO |
| 68 | Does arthritis run in your family? | YES | NO |
| 69 | Do weak or painful feet make your life miserable? | YES | NO |
| 70 | Does back pain make it difficult to get through your day? | YES | NO |
| 71 | Are you troubled with a serious disability or deformity? | YES | NO |

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|----|---|-----|----|
| 72 | Is your skin very sensitive or tender? | YES | NO |
| 73 | Do cuts and bruises heal slowly? | YES | NO |
| 74 | Does your face often get badly flushed? | YES | NO |
| 75 | Do you sweat a great deal even in cold weather? | YES | NO |
| 76 | Are you often bothered by severe itching? | YES | NO |
| 77 | Does your skin often break out in a rash? | YES | NO |
| 78 | Are you often troubled with acne or boils? | YES | NO |

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79	Do you suffer from frequent headaches?	YES	NO
80	Does pressure in the head often make life miserable?	YES	NO
81	Are headaches common in your family?	YES	NO
82	Do you have hot or cold spells?	YES	NO
83	Do you often have spells of dizziness?	YES	NO
84	Do you frequently feel faint?	YES	NO
85	Have you fainted more than twice in your life?	YES	NO
86	Do you have numbness or tingling in any body part?	YES	NO
87	Was any part of your body ever paralyzed?	YES	NO
88	Were you ever knocked unconscious?	YES	NO
89	Have you at times had a twitching of the face or head?	YES	NO
90	Did you ever have convulsions or seizures?	YES	NO
91	Has anyone in your family had convulsions or seizures?	YES	NO
92	Did you ever bite your nails badly?	YES	NO
93	Have you ever been troubled by stuttering or stammering?	YES	NO
94	Are you a sleep walker?	YES	NO
95	Are you currently a bed wetter?	YES	NO
96	Were you a bed wetter as a child?	YES	NO

H - **FEMALE ONLY**

97	Were or are your menstrual periods usually painful?	YES	NO
98	Have you often felt weak or sick with your periods?	YES	NO
99	Have you often had to lie down during your period?	YES	NO
100	Are you usually tense or jumpy with your periods?	YES	NO
101	Do you have frequent hot flashes and sweats?	YES	NO
102	Have you often been troubled with vaginal discharge?	YES	NO
103	Do you frequently get up at night to urinate?	YES	NO
104	During the day, do you have to urinate frequently?	YES	NO
105	Do you often have burning pain when you urinate?	YES	NO
106	Do you sometimes lose control of your bladder?	YES	NO
107	Have you ever had kidney or bladder disease?	YES	NO

H - **MALE ONLY**

108	Have you ever had a health problem with your genitals?	YES	NO
109	Are your genitals often painful or swollen?	YES	NO
110	Have you ever had treatment for your genitals?	YES	NO
111	Have you ever had an inguinal hernia?	YES	NO
112	Have you ever passed blood while urinating?	YES	NO
113	Do you have difficult or slow urination?	YES	NO
114	Do you frequently get up at night to urinate?	YES	NO
115	During the day, do you urinate frequently?	YES	NO
116	Do you often have burning while urinating?	YES	NO
117	Do you sometimes lose control of your bladder?	YES	NO
118	Have you ever had kidney or bladder disease?	YES	NO

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119	Do you often feel completely exhausted or fatigued?	YES	NO
120	Does working tire you out completely?	YES	NO
121	Do you usually wake up tired and exhausted?	YES	NO
122	Does every little effort wear you out?	YES	NO
123	Are you frequently too tired and exhausted to eat?	YES	NO
124	Do you suffer from frequent nervous exhaustion?	YES	NO
125	Does nervous exhaustion run in your family?	YES	NO

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126	Are you frequently ill?	YES	NO
127	Are you frequently confined to bed by illness?	YES	NO
128	Are you frequently in poor health?	YES	NO
129	Are you considered a sickly person?	YES	NO
130	Do you come from a sickly family?	YES	NO
131	Do aches and pains make it difficult to work?	YES	NO
132	Do you wear yourself out worrying about your health?	YES	NO
133	Are you frequently depressed and unhappy?	YES	NO
134	Do you feel over whelmed due to poor health?	YES	NO

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135	Did you ever have scarlet fever?	YES	NO
136	Have you had rheumatic fever?	YES	NO
137	Did you ever have malaria?	YES	NO
138	Were you ever treated for anemia?	YES	NO
139	Have you been treated for a sexually transmitted disease?	YES	NO
140	Do you have diabetes?	YES	NO
141	Did a doctor ever say you had a goiter?	YES	NO
142	Have you ever been treated for a tumor or cancer?	YES	NO
143	Did you suffer from any chronic disease?	YES	NO
144	Are you definitely under weight?	YES	NO
145	Are you definitely over weight?	YES	NO
146	Do you have varicose veins in your legs?	YES	NO
147	Have you ever had surgery?	YES	NO
148	Did you ever have a serious injury?	YES	NO
149	Do you often have small accidents or injuries?	YES	NO

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150	Do you have difficulty falling asleep or staying asleep?	YES	NO
151	Do you find it impossible to take a rest break daily?	YES	NO
152	Do you find it impossible to exercise daily?	YES	NO
153	Have you ever or do you smoke tobacco? Packs/day? _____	YES	NO
154	Do you frequently drink coffee or tea?	YES	NO
155	Do you frequently drink alcohol?	YES	NO



Acct # _____

Physical, Emotional and Chemical Stress History

Name _____ Date ____ / ____ / _____

Five most recent accidents: Slips, Falls, Car Crashes etc.

1 _____	Year _____
2 _____	Year _____
3 _____	Year _____
4 _____	Year _____
5 _____	Year _____

Percentage of time you sleep in the following positions Stomach _____ Right Side _____ Left Side _____ Back _____

Total sleep hours per night _____ Peaceful Restless **Do you wear custom fit orthotics** Yes No

List sports played as a child _____

List any broken bones _____

Stress level Scale 0 - 10 (10 WORST) 0 1 2 3 4 5 6 7 8 9 10

Energy level Scale 0 - 10 (10 BEST) 0 1 2 3 4 5 6 7 8 9 10

Dietary habits (Circle)

Coffee	Soda	Diet Soda	Alcohol	Sweets	Artificial Sweeteners	Sugarless Gum	GMO foods
Smoking Tobacco	Smokeless Tobacco	Organic foods	Non-Organic meats	Organic meats	Dairy		

List disease history _____

List surgery history _____

List current exercise habits _____

List your TOP 3 Goals regarding your health _____



Policies for Patients

Acct # _____

To help you receive our best, all patients are accepted for care understanding the following office policies.

Payment: Payment is expected when service is rendered. When unexpected health needs arise, unexpected expenses strike as well. Premier Sports Chiropractic of Geist understands this and can make special arrangements with an estimated monthly budget payment option. We accept HSA cards, debit cards, credit cards (Visa, Master Card, Discover and American Express), checks, and cash. There will be a monthly service charge for account balances that are past due.

Scheduling: Schedule all appointments in advance and refrain from repeated rescheduling. Any missed appointment should be rescheduled as a make-up visit within 7 days. **As of January 1, 2015 Rescheduled, No Show and Cancellation appointments that we are notified less than 24 hours in advance will result in a charge of \$85.00.** Please help us serve you better by keeping your scheduled appointments.

Workshops: Our workshop schedule is posted on our website and on the white board in the office. Patients who attend these workshops get well faster and spend less money on health care over time. These workshops are designed to answer your questions and help you to improve and modify your lifestyle choices.

Cell phones: As a courtesy to our staff and other patients, turn off or silence your phone before stepping into the office. Please step outside if you must use your phone.

Food and Drinks: Please do NOT bring food and drink into the office.

Insurance: If you have insurance you must present your insurance card on your initial visit or at the beginning of a new year or at any time your insurance coverage changes. **Account balances will always be delayed when dealing with insurance due to the time required for completion of claims processing. Due to the delay in processing by most insurance claims we do not send out regular monthly statements as your account balance will change based on insurance processing.**

Please access your insurance company online and print out your declaration page with details of your chiropractic benefits, co pay and or deductible.

Please check the box above when completed.

When a patient seeks chiropractic health care and we accept a patient for care, it is essential for both to be working toward the same objective. **Our practice objective is to eliminate Subluxations that create interference within your nervous system.** Your prescribed care plan is designed with this in mind. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment. If during the course of chiropractic examination we recognize non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Patient Signature _____ Date ____ / ____ / _____