CHIRO4SPORTS

Jeffrey Ho DC, Windward Chiropractic & Wellness Inc. D/B/A CHIRO4SPORTS

Name: _____ **Date:**_____

Address: _____

City: _____ **State:** _____ **Zip:**_____

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

Email: _____

Date of Birth: _____ **Age:**_____ **Marital Status: M S D W**

Social Security #: _____ **Occupation:** _____

Employer: _____

Spouse's Name: _____ **Age:** ____ **Occupation:** _____

How many Children do you have?_____

Have they or any other members of your family received Chiropractic Care? _____

Do you have health insurance? Y N

Name of Company: _____ **Policy #:** _____

List any surgeries or hospitalizations: _____

List medications (prescription & over the counter) that you are currently taking or have taken in the last 6 months: _____

Daily intake: Coffee _____ **Tea** _____ **Alcohol** _____ **Tobacco** _____

Have you had chiropractic care in the past? Y N If yes, Dr. _____

Date of last chiropractic visit: _____ **Date of last chiropractic X-rays:** _____

Please mark (C) for current or (P) for past conditions for the following:

_____ Fractured bones	_____ Headaches	_____ Heart Problems
_____ Auto accidents	_____ Neck pain	_____ Stroke
____ 0-1 yr. Ago	_____ Low back pain	_____ High Blood Pressure
____ 1-5 yrs. Ago	_____ Mid back pain	_____ Lung Problems
____ more than 5 yrs. Ago	_____ Shoulder pain	_____ Cancer
_____ Knocked unconscious	_____ Pain in arms	_____ Diabetes
_____ Slip/Fall	_____ Hip pain	_____ Constipation
_____ Sporting Injury	_____ Pain in legs	_____ Digestive Problems
_____ Work accident	_____ Numbness in arms	_____ Allergies

INSURANCE NOTICE:

As a courtesy to you, this office will submit claims to your insurance company and prepare any necessary reports and forms to assist you in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to your account. Some of the care and services you receive may not be covered by insurance. If we have knowledge that a service or product is not covered by your insurance, we will do our best to notify you in advance. However, your insurance policy is a contract between YOU and the INSURANCE COMPANY. You are ultimately responsible for payment in full if the carrier determines that a service or product in not covered by your policy.

I, _____, attest that I have read and fully understand the above statements.

_____ _____
Signature **Date**

CONSENT FOR MINOR:

I do hereby consent for examination and chiropractic care for _____, for whom I am the parent/ legal guardian.

_____ _____
Guardian's Signature **Date**

X-RAY CONSENT

The purpose of the x-ray examination is to analyze the spine for vertebral subluxation, rate, and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed and I must determine if I should seek further advice from an additional healthcare provider. I understand that this should not interfere with the subluxation correction care provided by this office. I fully understand the above and consent to chiropractic spinal x-rays.

Patient Signature_____ Date:_____

Pregnancy Release

This is to certify to the best of my ability I am not pregnant and Chiro4Sports has my permission to perform an x-ray evaluation. I understand the risks of taking an x-ray to an unborn child.

Date of last menstrual period:_____

Patient Signature:_____
Date:_____