Patient Welcome Form

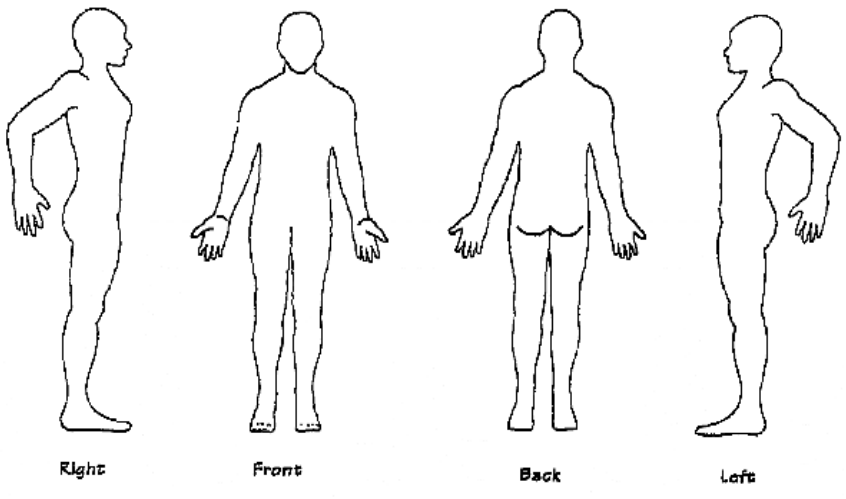
Name(LAST)_____(FIRST)_____(MI)_____
What you prefer to be called:_____ Male__ Female__
DOB:____/____/_____ Age:_____ SSN #:_____-____-_____
Mailing address:_____
(Street) (City & State) (zip code)
Cell # ( ) _____ E-mail: _____
Home # ( ) _____ Incase of Emergency Contact:
Work # ( ) _____ Name:_____ Phone #_____
Did someone refer you to our office? If so, who? _____
Status: Minor__ Single__ Married__ Divorced__ Separated__ Widowed__
Spouse's Name:_____ Do you have children? Yes No If so how many? _____

Employer Information:
Employer:_____Occupation_____
Employers address:_____
How Long? _____

……

What is the reason for your visit today?
Emergency___ New Injury___ Old Injury___ Chronic Pain ___ Wellness___
Are you in pain? Y N Please rate you pain on the scale: (DISCOMFORT)1..2..3..4..5..6..7..8..9..10 (INTENSE)
Did your injury occur during: Work__ Sports/play__ Auto Accident__ Routine Household Activity__
When did your condition/accident occur? ___/___/____ Where?_____
Please explain what happened:_____
Is your condition getting worse? Yes__ No___ Constant___ Comes and goes___
Is your condition interfering with your: Work___ Sleep___ or Daily routine___ If so, how?_____
_____
Has this or something similar happened in the past? Yes No
Please explain:_____

Please circle all affected areas on the body charts shown:
Have you been treated by a Medical Physician for this condition? Yes___ No___
If so, where?_____
Have you ever been treated by a Chiropractor? Yes___ No___
Clinic Name:_____ Clinic phone #:( )_____



Health History:

Are you taking any of the following medications? Nerve pills___ Pain killers (including aspirin)___
Muscle relaxers___ Blood thinners___ Tranquilizers___ Insulin___ Other:_____

Do you have or have had any of the following diseases, medical conditions, or procedures:

Y N Heart attack/Stroke Y N Heart surg./Pacemaker Y N Heart Murmur Y N Congenital Heart Defect
Y N Mitral Valve Prolapse Y N Artificial Valves Y N Venereal Disease Y N Hepatitis
Y N HIV/ AIDS/ ARC Y N Shingles Y N Cancer Y N Frequent Neck Pain
Y N Glucoma Y N Anemia/Diabetes Y N High/ Low Blood Pressuer
Y N Psychiatric Problems Y N Rheumatic Fever Y N Severe/ Frequent Headaches
Y N Kidney Problems Y N Ulcers/Colitis Y N Fainting/ Seizures/ Epilepsy
Y N Sinus Problems Y N Tuberculosis Y N Emphysema/ Asthma
Y N Difficulty Breathing Y N Chemotherapy Y N Lower Back problems
Y N Arthritis Y N Artificial Bones/ Joints/ Implants

Please list and surgeries with dates and/or and other serious medical condition(s) not listed:_____
_____
Please list any past serious accidents with dates:_____
Please list allergies you are aware of:_____
Family Heath History:_____
Do you take supplements or vitamins? No___ Yes___ Please list:_____
Do you exercise? No___ Yes____ Hours per week_____
Do you smoke? No___ Yes____ How much?_____ How long?_____
Are you a heavy drinker? No___ Yes_____ How much?_____ How long?_____
Are you dieting? No___ Yes____ Since:_____/_____/_____
Are your wearing: Shoe lifts____ Inner soles____ Arch supports____ How long?_____
For Women: Are you taking birth control? No____ Yes_____ What kind?_____
Are you pregnant? No_____ Yes_____ How many weeks?_____ Are you nursing No____ Yes____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

Conyers Chiropractic & Massage P.C.
2239 GA HWY 20 Suite D
Conyers, GA 30013
Phone: (770)922-8150
Fax: (770)922-8151