Houston County Chiropractic

2157 Denton Rd
Dothan, AL 36303
(334) 794-4648

Today's Date: ____ /____ / 20____ email: _____

Name: _____ Address: _____

City/State/Zip: _____ Marital Status: S M W D

Home Phone: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Date of Birth: ____ /____ /_____ Age: _____ Social Security #: _____ - ____ - _____

Employer: _____ Occupation: _____

Address: _____ City/State/Zip: _____

Spouse Name: _____ Spouse DOB: ____ /____ /_____

Please indicate payment type: Cash Check Visa/Master Card/Discover Other

Do you have Health Insurance: Yes No Plan/Group #: _____

Insurance Carrier: _____

Were you referred to our office? Yes No If yes, Who: _____

Please describe the major complaint(s) that brought you in today: _____

_____

Is your complaint due to an injury: Yes No If so, Date of injury: ____ / ____ / _____

Type of Injury: Auto Work Other _____

How does your complaint(s) affect your everyday life? _____

_____

On a scale of 1 to 10 (1=**no** pain, 10=**extreme** pain) how would you rate your pain: _____

Have you ever been adjusted by a Chiropractor? Yes No If so when: ____ /____ /_____

List any past surgical procedures: _____

_____

List any medications your taking: _____

_____

History: Please mark any condition(s) that applies to yourself **or** a family member.

( ) Allergies	( ) High Blood Pressure	( ) Head Injury
( ) Vision Problems	( ) Hearing Problems	( ) Concussions
( ) Diabetes	( ) Asthma	( ) Heart Problems
( ) Seizures	( ) Cancer	( ) Bowel Problems
( ) AIDS	( ) Anemia	( ) Bladder Problems
( ) Headaches	( ) Numbness/Tingling	( ) Urinary Problems
( ) Sinus Problems	( ) Backaches	( ) Reproductive Problems
( ) Neck Pain	( ) Multiple Sclerosis	( ) Respiratory Problems
( ) Chronic Fatigue	( ) Fibromyalgia	( ) Epilepsy
( ) Spinal Surgery	( ) Psychological Problems	( ) Muscular Dystrophy
( ) Herniated Disc(s)	( ) Digestive Problems	( ) Fainting
( ) Broken Bones	( ) Constipation	( ) Dizziness
( ) Paralysis	( ) Diarrhea	( ) Other _____

Are you interested in:	( ) Lasting Correction	( ) Wellness Care
	( ) Symptom Relief	( ) Family Care

In the event of a scheduling error or unforeseen office closing please list someone we can contact who will always know where to reach you:

Name: _____ Address: _____

Home Phone: ( ) _____-_____ Work: ( ) _____-_____

Patients with Insurance: As a courtesy we will file your insurance for you, although that does not guarantee reimbursement. Ultimately you will be responsible for any outstanding balance if your insurance denies payment for covered or non-covered services rendered in our office. If you have any questions about your financial responsibilities please ask at the front desk prior to seeing the Doctor. We offer flexible payment plans to make it affordable to get the care you need without making it a financial burden. Family plans are also available, so if you're interested please ask at the front desk for more details.

Chiropractic Examination and Analysis: As a part of the examination I consent to the following procedures to determine if Chiropractic care is suitable for my condition.

Vital Signs	Neurological Testing	Range Of Motion Testing
Radiographic Studies	Orthopedic Testing	Palpation
Thermography Scan	Postural Analysis	

Patient's Signature: _____ Date: ____ /____ /20_____

Spouse or Guardian's Signature: _____ Date: ____ /____ /20_____

*Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made before seeing the Doctor. Also, on all insurance the deductible must be met in the beginning unless prior arrangements are made.