Initial Health History Form
Dr. Janelle Chiropractic Inc.

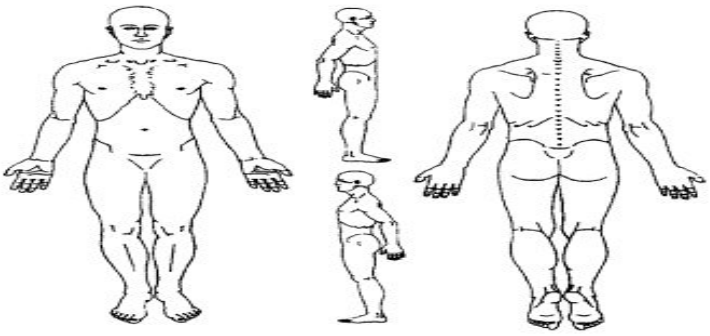
Date_____
Name (please print):_____
Address:_____
City:_____ State: _____ Zip: _____
Birth Date: _____ Age _____ Height _____ Weight_____
E-mail : _____ Cell Phone: _____

Insurance name_____ I.D.#_____
Name & DOB of Insured (If not self)_____
Exact Address & Cell # On File With Insurance Company (If different than above)_____
How Did You Hear About Us_____

<u>If Here Due To An Automobile Accident Please Fill Out Below</u>
Date of accident_____What Happened:_____
_____
_____
3rd party (person at fault) Ins Co_____ Claim#_____
Adjuster's Name_____ Phone#_____
Your Auto Ins Co._____ Claim#_____
Lawyer_____ Phone#_____ Fax:_____

Occupation and Typical Posture: _____
What's your reason(s) for seeking care? List ALL your major complains today:
_____
_____
_____

Please circle your areas of pain on the figures below, And circle the description(s) that best describes your discomfort.



Pain & discomfort
Sharp & Stabbing
Dull & Achy
Pins & Needles
Numbness
Weakness
Tingling
Temperature Change
Tender

Accidents: Please list related accidents, include dates. (car, bicycle, motorcycle, sports, falls)_____
_____

Surgeries/Conditions: Please list major surgeries, broken bones or conditions, include dates._____
_____

Medications/Supplements: Please list prescription & over-the-counter medications you are currently taking & their purpose(s)._____
_____

Dr Janelle Likes to text and/or email for appointment reminders, office closure, birthday, etc. Please let us know if you do not want us to text or email you. Thanks!

Payment is expected at the time of visit. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Janelle Chiropractic Inc to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

The Information provided is to the Best of my Ability and is True and Accurate:

Sign:_____ Date:_____

Please Print Name:_____

For Treatment Of Minor:
I hereby request and authorize Dr. Janelle Chiropractic Inc, to administer chiropractic care and therapies as deemed necessary to my dependent minor child.
Childs Name:_____Your Relationship to Child:_____
Today's Date:_____Signature Parent/Guardian:_____
Print Name of Parent/Guardian:_____
Parent/Guardian Phone #:_____