Welcome to Madeira Beach Center for Natural Medicine

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. Please print it and bring it with you to your appointment. We look forward to working with you in maintaining your health. . . Naturally.

Patient Information

Name_____ Soc. Sec. #_____

Address_____

City_____State_____Zip_____

Phone: Home_____Work_____Mobile_____

SexF__ M__Age___Birthdate_____Single__Married__Widowed
Separated__Divorce__Partner__

Employer_____Occupation_____

Business address_____E-Mail_____

Who may we thank for referring you?_____

Notify in case of emergency_____HomePhone_____ Cell Phone _____

Insurance Information

(**MEDICARE OR PIP—AUTO ONLY**)

Person Responsible for account _____

Relation to Patient _____ Birth Date_____ Soc. Sec.#_____

Address (if different from Patient) _____

City _____ State _____ Zip _____ Phone_____

Insurance Company _____ Phone_____

Mailing Address:_____

Contract (ID) # _____ Group # _____ Subscriber #_____

Claim # _____

Reason for Visit

Have you ever seen a chiropractor? __ yes __no Acupuncturist? __yes __no

Your reason for today's visit: _____

Please describe any current pain and the location: _____

When did symptoms begin?_____ What do you believe to be the cause of this pain condition?_____

Have you ever had similar conditions in the past?_____If yes, when?_____

Have you seen any therapist or other health care practitioner for this condition?_____If yes, what was the outcome?_____

Are there any conditions that you wish to be addressed?_____

Health History

Please list any medications you are taking: _____

_____

Please list any nutritional supplements or herbs you are taking:_____

_____

Please list any injuries or surgeries you have had in the last ten years:

	Description	Date
Falls	_____	
Head injuries	_____	
Broken bones	_____	
Dislocations	_____	
Surgeries	_____	
Other serious injuries	_____	

Women: Are you pregnant? Yes_____ No _____

When was your last Pap smear? _____ Mammogram?_____

Men: when was your last prostate exam? _____ PSA blood test? _____

Medical Conditions

__Heart attack/stroke	__Arthritis	__Ringing in ears	__Allergies
__Congenital heart defect	__Frequent neck pain	__Headaches	__Hypertension
__Alcohol/drug abuse	__Jaw pain	__Diabetes/tuberculosis	__Crohn's
__Fainting/seizures/epilepsy	__Wrist pain	__Dizziness	__Skin concern
__Shingles	__Shoulder pain	__Gout	__Tendonitis
__Psychiatric problems	__Arm pain	__Kidney problems	__Anemia
__Difficulty breathing	__Leg pain	__Artificial bones/joints	__Cancer
__Hepatitis	__Lower back problems	__Bleeding disorder	__Excess stress
__Chronic diarrhea	__Chronic constipation	__HIV positive/AIDS	__Excess gas

__Other health conditions_____

Personal History

	Heavy	Moderate	Light	None
Alcohol	__	__	__	__
Coffee	__	__	__	__
Tobacco	__	__	__	__
Drugs	__	__	__	__
Exercise	__	__	__	__
Appetite	__	__	__	__

How many hours of sleep do you get each night? _____

How many bowel movements do you have a week? _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that the doctor will use this information to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the doctor before further treatment is administered.

I authorize my insurance company to pay the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the release of information necessary to secure payment of benefits. I understand that I am financially responsible for all services not covered by my insurance.

Signature _____Date _____