

**Patient Information** required

Full Name: \_\_\_\_\_

I prefer to be called : \_\_\_\_\_

Age : \_\_\_\_\_ Birthdate : \_\_\_\_\_

Social Security # : \_\_\_\_\_

Address : \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone 1: \_\_\_\_\_

Work/ Daytime Phone 2: \_\_\_\_\_

E-mail address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Address (city) : \_\_\_\_\_

Bank (name & city) : \_\_\_\_\_

**Family Status:** Single Married Divorced Widowed

If married:

Spouse name: \_\_\_\_\_

Work/ Daytime phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Worker's Compensation** (if applicable):

Name of Employer : \_\_\_\_\_

Claim # : \_\_\_\_\_

WC Administrator : \_\_\_\_\_

Address : \_\_\_\_\_  
\_\_\_\_\_

Phone # : \_\_\_\_\_

**Privacy Policy**

By signing, you acknowledge that you have read and understand our privacy policy.

**Financial Policy and Authorizations**

If your health insurance requires pre-authorization or referral, please be sure that you have taken care of this responsibility before our office performs billable services.

**You are responsible for payment of all charges incurred at Performance Chiropractic. This responsibility extends to the total charges without regard to possible insurance benefits or determinations of necessity. Wellness treatments are not covered by or submitted to insurance.**

You authorize Performance Chiropractic to request and/or release medical records to/from your insurance company and your referring and/or family physician.

We will file your insurance claims (if applicable) for you, and you authorize the assignment of all benefits to Performance Chiropractic.

You agree to pay any and all collection costs generated in the collection of payment for all charges incurred at Performance Chiropractic. If they become necessary, these collection costs include but are not limited to special postage expense, collection agency fees, attorney fees, and court costs.

**Payment is expected at time services are rendered.** We reserve the right to charge a \$50 missed appointment fee.

*Your initials indicate that you have read, understand, and accept all terms:*

Performance Chiropractic  
1307 Jamestown Road; Suite 103, Williamsburg

**New Patient Admin & Clinical**  
Updated: 07.30.08

Patient Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
*If patient is under 18 years old, parent or guardian must sign : \_\_\_\_\_*

**Previous and Current Health Care**

*Include dates and doctors' names.*

*If not applicable, please write "none" or "N/A"*

Family/primary care physician: \_\_\_\_\_

Please describe recent medical or other care:

\_\_\_\_\_  
\_\_\_\_\_

Please describe previous chiropractic care:

\_\_\_\_\_  
\_\_\_\_\_

Please describe any medications you take regularly (prescription or over the counter):

\_\_\_\_\_  
\_\_\_\_\_

Please describe any surgery you have had, including dental and elective surgeries:

\_\_\_\_\_  
\_\_\_\_\_

Please describe any injury you have had, including falls, car accidents, etc:

\_\_\_\_\_  
\_\_\_\_\_

Please list your family medical history (diabetes, cancer, high blood pressure, stroke, heart attack, family diseases, etc.).

Indicate relationship (eg. parent, grandparent, sibling):

\_\_\_\_\_  
\_\_\_\_\_

Please circle your current level of activity:

Regular      Occasional      None

Is your activity aerobic (raises your pulse for at least 20 minutes, 3 times/week)?      Yes    No    N/A

Use of Smokeless Tobacco: \_\_\_\_/day

Use of Alcohol: \_\_\_\_drinks/day

Use of Caffeine : \_\_\_\_drinks/day

Do you currently smoke?      Yes    No

If yes, how many packs per day ?

<1      1      2      3>

For how many years ? \_\_\_\_\_

Have you quit smoking?      Yes    No

If yes, when did you quit ? \_\_\_\_\_

How many packs per day did you smoke ?

<1      1      2      3>

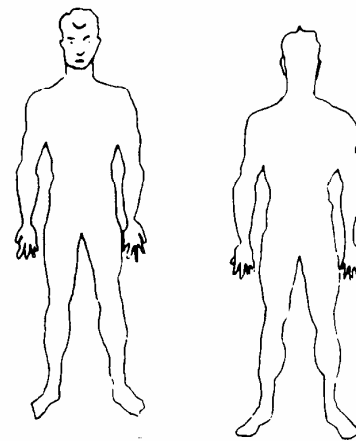
For how many years ? \_\_\_\_\_

Have you ever been a victim of abuse?    Yes    No

(This question allows us to be sensitive to your needs, and is intended to assist you in seeking appropriate resources if you have not yet done so.)

**Current Areas of Concern**

*Please mark areas of concern on these diagrams:*



*Please list below the main complaints you have, in order of importance.*

Describe pain: what & where      How long?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

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