Horizon Chiropractic And Wellness Solutions **Eric D. Terrell, D.C., F.I.A.M.A.**
Please complete ALL information legibly (if none or not applicable, please indicate so):

PERSONAL INFORMATION
First Name:________________________________
M.I. ________________________________
Last Name: ________________________________
Nickname:________________________________
Street:________________________________
City:________________________________
State:____________________Zip: _______________
SSN:________________________________
Gender □ Male □ Female
Status: □ Single □ Married □ Widowed □ Divorced
Spouse:________________________________
Patient Date of Birth:________________________
Child (ren): (name/age)________________________
How did you find us?____________________

INSURANCE INFORMATION □ No Coverage
Insurance Co. Name:__________________________
Policyholder Name:__________________________
Relation to Client: □ Self □ Spouse □ Child □ Other
Policyholder DOB:____________Gender:_________
*** Please present Insurance ID card to the front desk ***

ACCIDENT/INJURY INFORMATION
Have you ever been in or had:
□ Auto Accident-Date(s):______________________
□ Personal Injury-Date(s):_____________________
□ Other Trauma-Date(s):_________________
Describe Incident(s):____________________
Treatment Received:____________________

SURGICAL/HOSPITAL INFORMATION
Have you ever had surgery? □ Y □ N
If Y, reason:________________________________
Have you ever been hospitalized? □ Y □ N
If Y, reason:________________________________

CONTACT & WORK INFORMATION
Home Phone: (______)________________________
Work Phone: (______)___________ ext:_________
Fax Number: ( )________________________________
E-Mail:________________________________
Cell / Pager: ( )________________________________
Occupation:________________________________
Employer:________________________________
Address: ________________________________
City/State/Zip:____________________________
Type of Work: □ Sitting/Computer □ Standing □ Labor
Emergency Contact:________________________
Emer. Phone: (______)________________________

PREVIOUS CHIROPRACTIC CARE
Have you ever received chiropractic care? □ Y □ N
Doctor Name:________________________________
City/State:________________________________
Reason:________________________________
____

REASON FOR TODAY'S VISIT
Please describe the reason(s) for today's visit:
____

MEDICINE USE - DO YOU TAKE . . .
□ Over-the-Counter Medicines Regularly
□ Prescription Drugs for Illness/Chronic Condition
□ Vitamin Supplements □ Herbal Supplements
□ Hormone Supplements □ Other:

FAMILY MEDICAL HISTORY
Please mark if you and/or any family member has had:
□ Stroke □ Dizziness □ Heart Attack
□ Anemia □ Backaches □ Hypoglycemia
□ Epilepsy □ Diabetes □ Thyroid Problems
□ Pleurisy □ Cancer □ Low Blood Pressure
□ Arthritis □ Heart Disease □ High Blood Pressure

LIFESTYLE & HABITS INFORMATION

Please answer each of the following questions:

	NO	YES	Comments
Do you exercise?	N	Y	how many times/week______________________
Do you smoke?	N	Y	how many packs/day________________________
Do you consume alcoholic beverages?	N	Y	how many beverages/day
Do you visit the dentist regularly?	N	Y	how many times/year______________________
Do you have an annual physical?	N	Y	Routine blood work done yearly □ No □ Yes
Do you know if you cholesterol is normal?	N	Y	what is your cholesterol level________________
Do you know if your blood pressure is normal?	N	Y	what is your blood pressure_________________
Do you wear a seat belt while in the car?	N	Y	always □ sometimes □ never □
Do you eat fast food or packaged foods?	N	Y	always □ sometimes □ never □
Do you sleep well - at least 5 hours a night?	N	Y	□restful □fitful wake often don't get enough
Do you have a regular sleeping position?	N	Y	□back □side □stomach □all □without pillow
Do you have a stressful job, home, or other environment?	N	Y	rate your stress level (1 low - 10 high)_________
Women: Is there any chance you could be pregnant?	N	Y	date of last menstrual cycle_________________

How would you rate your approach to wellness? (Only go when sick) ….1....2....3….4....5.... (Prevention oriented)

Wellness Questions

I want to:	Not committed									Committed		N/A
Lose weight	0	1	2	3	4	5	6	7	8	9	10	
Lower cholesterol naturally	0	1	2	3	4	5	6	7	8	9	10	
Lower blood sugar /pressure naturally	0	1	2	3	4	5	6	7	8	9	10	
Reduce stress	0	1	2	3	4	5	6	7	8	9	10	
Slow down the aging process	0	1	2	3	4	5	6	7	8	9	10	
Improve energy & endurance	0	1	2	3	4	5	6	7	8	9	10	

Would you like us to assist you in reaching these objectives? Yes No

FINANCIAL RESPONSIBILITY INFORMATION

*Payment is expected at the time services are rendered.

*Payments are accepted in the form of check, credit card (visa/mastercard/discover) and cash. Advance payments are always welcome. Please pay "ahead, or on time, but never behind."

*If there is no insurance policy, the client shall follow the standard office guidelines for payment.

*We will gladly verify insurance benefits and file all insurance and 3rd party claims. The client/insured is responsible to pay estimated amounts (based on quotes by the insurance carrier) at the time services are rendered.

*Any amounts reduced, not-allowed, and/or not covered by the insurance carrier become the immediate responsibility of the insured (except in the case of contractual agreements between the provider and carrier).

*The insured is responsible to know and pay according to the insurance policy and its restrictions, limitations, and guidelines. If you have questions, please check the carrier's master policy.

*The client/insured (or parent, if minor) is ultimately responsible for any and all fees incurred, regardless of quoted or implied insurance or 3rd party insurance carrier involvement.

*Services are rendered in good faith that timely payment will be made and that no account will become delinquent. Any account requiring collection action will incur legal fees that are the responsibility of the client.

I have read & understand the above terms and conditions.

A client (or parent, if minor) signature constitutes acceptance.

___________________________________ ______________

Client Signature Date