Gateway to Wellness Chiropractic

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Patient Information

Date: ______________________________

Name: ______________________________

Nickname: ______________________________

Age: _____ Date of Birth: ________________

Social Security No: ____________________

Sex: ❑F ❑M Marital Status: S M D W

Home Address: ________________________

____

Email Address: ________________________

Home Phone: __________________________

Work Phone: __________________________

Cell Phone: ___________________________

Emergency Contact: ____________________

Emergency Contact Phone:

____

Spouse/Significant Other:

____

No. Of Children: ____Their Ages: ____________

Occupation: ___________________________

Employer: _____________________________

Is your condition related to an accident?

❑Yes ❑No Date: ____________________

If yes, please inform our staff and obtain additional necessary paperwork.

How did you hear about our office?

____

Payment Information

If you are interested in utilizing an insurance policy for any part of your financial obligation please complete the following and allow us to make a copy of your insurance card. If you will not be using insurance, please be sure to read our payment policies form for paying “out of pocket”.

Name of Insured: __________________________ Insured’s DOB: ____________________

Insured Social Security#: ____________________ Relation to Patient: __________________

Insurance Company: _________________________ Policy ID#: ______________________

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above written company and assign directly to Dr. Jonathan A. Guymon all insurance benefits, if any, otherwise payable to me, as payment for services rendered.
I agree to be financially responsible for all charges incurred at this clinic, whether or not they are paid by insurance.
I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof.
I agree that a photostatic copy of this agreement shall serve as the original.
I authorize the use of this signature on all insurance submissions.

Signature: ______________________________________ Date: ______________________

What are your top 3 health objectives?

1.____

2.____

3.____

Name/Address/Phone of the last doctor who put you on a health development program?

____

Were you able to stay on the program?______ How long?____________________________

What were your results?____

Were your results permanent?____

How is your health compared to 5 years ago?______________________________

____

Will you be healthier 5 years from now than you are today?___________________________

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline?

____

Where would you like your health to be 5 years from now? _________________

____

How does your health limitation affect your life?

____

Home:____

Work:____

Hobbies:____

How would you rate your stress level(1-10,10 being the most stressful):

Home:______ Work:_______

How would you rate your(1-10, 10 being the best): Sleep____ Exercise____ Nutrition____

Emotional____ Overall Health____

Does This Condition Disrupt?	What Methods have You Tried?	Check all TRUE statements:
__Career	__Exercise	__Previous methods ineffective
__Family Life	__Physical Therapy	__My problems could get Worse
__Ability to Exercise	__Prescription Drugs	__I want to be energetic again
__Sleeping Pattern	__Massage	__I want answers and/or results
__Social Life	__Nothing	__I want to be healthy

Personal Health History

CIRCLE the following conditions that YOU have ever had and WRITE the date(s) they occured.

Headaches/Migraines	Low Energy/Tired	Scoliosis
Sinus/Allergies	Shoulder/Arm Pain	Disc Problem
Neck Pain	Numbness/Tingling	Leg/Hip Pain
Dizziness	Mid-back Pain	Muscles Stress
Ear Aches	Sciatica	Constipation
Asthma	Low Back Pain	Hyperactivity
Frequent Colds/Flu	Stomach Problems	Wrist/Joint Pain
Car Accident	Chemical Stress	Emotional Stress
Pregnancy	Physical Stress	Depression
Attention Disorders	High Blood Pressure	Stroke
Cancer	High Cholesterol	Thyroid Problem

WOMEN: Date of last menstrual period: ___________
Spinal health is especially important during pregnancy. Are you currently pregnant? ❑ Yes ❑ No
Due Date: ______________ Name of OBGYN/group: ______________________________
Where will you be birthing your baby? Hospital, Home, Birthing Center, Other__________

Please list all surgeries you have undergone and their corresponding dates:

Please list all current prescription and non-prescription drugs by name and purpose:

Please list all current Vitamins and supplements that you are currently taking:

The Statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

__________________________ Signature

_____________ Date