SINGER FAMILY CHIROPRACTIC
2010 INTERNET APPLICATION FOR CARE

Please complete all questions. We're looking forward to seeing you.

Today's Date:_____

Full Name:_____ Name I wish to be called:_____
Date of Birth:_____ Age:____ Who may we thank for referring you?_____

Home Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone Number:_____ Cell Phone:_____
E-mail address: _____

Your Employer:_____
City:_____ Work Phone:_____ Ext: _____
Position: _____

Primary/Best number for contact: Cell Home Work

Marital Status: Single Married Divorced Separated Widowed Other:_____
Spouse's Name:_____ Children's Names and Ages: _____
_____

Current health complaint(s) / Reason for consulting our office:
_____

Have you had chiropractic care in the past? Yes No
If yes: 1. How long ago was your last adjustment? _____
2. Did you go on a regular basis or just "as needed?" _____
3. Rate your past care: Excellent Good Fair Poor

Favorite hobbies and/or interests:_____

Present exercise regiment:_____
_____

Tobacco Use: NO YES If yes, how much?:_____
Alcohol Use: NO YES If yes, how much?:_____

List any and all operations you have had:_____
_____
_____

Drugs/Prescriptions are the THIRD leading cause of death in the US today. Are there any you're currently taking (and *what are they for*):_____

_____

_____

Health Insurance

I authorize Dr. Lewis Singer to release any and all information he deems appropriate concerning my physical condition to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges as a result of professional services rendered and hereby release Dr. Singer, Singer Family Chiropractic and all employees of any consequences thereof.

_____ _____

Signature Date

X-ray/Radiographic Policy

Our policy regards all X-rays/radiographs taken as part of your permanent medical record. **Any payment made for X-rays is made for the production and analysis of those pictures, not for the actual pictures themselves.** *All X-rays taken are the property of Singer Family Chiropractic and Dr. Lewis Singer. We do not release our films to our patients.* I have read and understand the above policy:

_____ _____

Signature Date

Non-Pregnancy Verification
(females only)

Date of last menses (period):_____
Method of prevention: _____Abstinence _____Condoms _____BC Pill ____IUD
_____Tubal ligation _____Hysterectomy _____Timing _____None
Other:_____
I hereby notify all concerned, that I neither suspect nor positively know at this time that I may be or am pregnant. I release Singer Family Chiropractic and Dr. Lewis Singer from any and all damages arising from any and all procedures of a diagnostic or treatment nature with reference to the possibility of pregnancy.

_____ _____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I am, by this statement, notified that a copy of the Office Privacy Policies is on the internet website to be viewed at any time and I may request my own copy anytime as well.

_____ _____

Signature Date

Please circle or check the additional problems you now have or have had within the past TWELVE months.

Musculoskeletal/General

Low Back Pain	Sciatica	Spinal Stenosis	Upper Back Pain
Neck Pain	Arm Pain	Joint Pain / Stiffness	Scoliosis
Difficulty Chewing/Clicking Jaw		Walking Problems	
Carpel Tunnel/Wrist Pain		Disc Herniations	

Nervous System

Nervousness	Numbness/Tingling: Where?_____	
Depression	Cold/Tingling Extremities	Stress
Convulsions	Anxiety	Dizziness

General

Fatigue	Allergies	Difficulty w/Sleeping
Headaches:(type)_____		Diabetes
Cancer:(type/area)_____		Epilepsy/Seizures
Acquired Immune Deficiency Syndrome		Low Thyroid function
Arthritis⊗type/area)_____		

Eyes/Ears/Nose/Throat

Vision Problems	Dental Problems	Frequent Sore Throat
Earaches	Hearing Difficulty	Asthma
Frequent colds		

Gastrointestinal

Gas/Bloating after meals	Poor Appetite	Excessive Thirst
Heartburn	Colitis/Irritable Bowel Syndrome	Diarrhea
Frequent Nausea	Constipation	Vomiting
Hemorrhoids	Liver Problems	Abdom. Cramps
Gallbladder Problems	Weight Trouble	Ulcers

Cardiovascular

Chest Pain	High Blood Pressure	Short Breath
Irregular Heartbeat	Heart Problems	Stroke
Lung Problems / Congestion	Ankle Swelling	Varicose Veins

GenitoUrinary

Bladder Trouble	Excessive Urination	Painful Urination	Prostate Proble

Females Only

Menstrual Irregularity	Vaginal Pain / Infection	Menstrual Cramps
Breast pain / Lumps	Pre-menstrual Syndrome	Post-partum Depre

Family History: The following members have the same or similar problems:

Mother	Father	Brother	Sister	Spouse	Child

Singer Family Chiropractic

Body Signal Form

Name: _____ Date: _____

Please list your chief complaints below giving them a rating of
1 (very minimal in intensity) to 10 (the worst pain you could ever imagine).

1. _____ ___/10
2. _____ ___/10
3. _____ ___/10

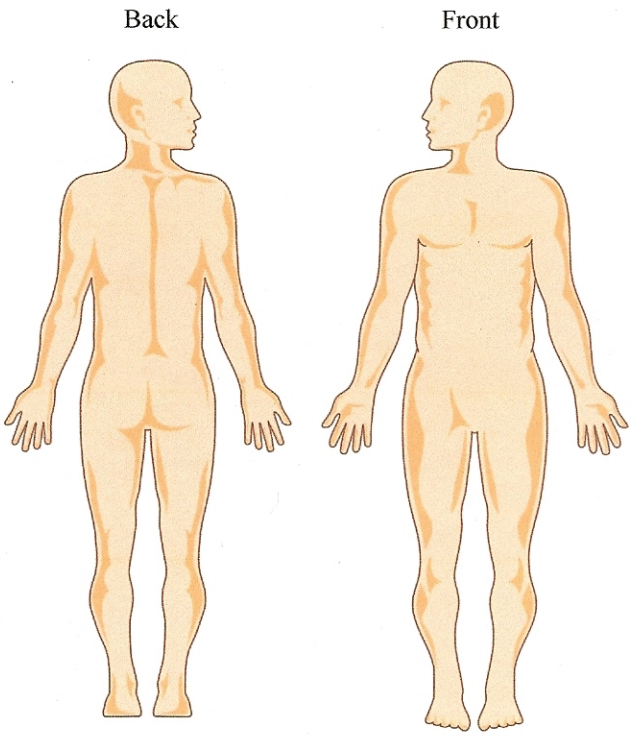
Overall, my symptom(s) is/are getting:

☐ BETTER ☐ WORSE ☐ STAYING THE SAME

Below, please mark the areas on your body where you feel the problem(s).

Numbness ==== Dull Ache 00000 Hot/burning XXXX

Sharp/shooting / / / / Pins and needles: + + + +



Signed: _____ Date: _____