

WELCOME TO DR. MARKO FAMILY CHIROPRACTORS

Please answer the following questions to the best of your ability, and return it to the front desk.

PATIENT INFORMATION

Name: _____ Date of Birth _____ S.S # _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____ E-Mail _____
Phone: (H) _____ (W) _____ Referred to our office by: _____
Name of Spouse: _____ Parent/Legal Guardian _____ Children _____
Occupation _____ Employer Name and Address _____
Height: _____ Weight: _____ Any recent gains or loss? _____ Name of nearest relative/ phone number _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Insured's Name and Birth date _____
Relationship to patient _____ Insurance Co. Name and Address _____
Group Number _____ Policy Number (ID #) _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Marko all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

ACCIDENT INFORMATION

Is this condition due to an accident? **Yes No** Date of accident _____ Type of Accident (circle one) Auto Work Home Other
Was this reported? **Yes No** Attorney Name and Phone Number (if applicable) _____

REASON FOR THIS VISIT

Reason for visit: _____ When was the first time you were aware of it? _____

Wellness check up _____ (No symptoms, I would like to be checked for Vertebral Subluxations)

How did this condition develop (what caused it)? _____

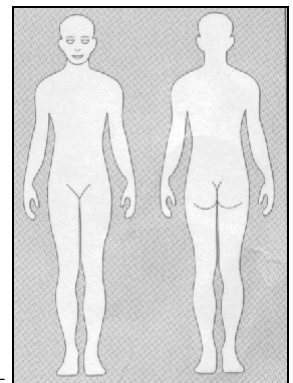
Have you ever had the same or similar problem before? **Y N** Is this condition getting worse? **Y N**

Rate the severity of your symptoms, on a scale of 1-10 (1 being the least, 10 being most severe) _____

Mark an X on the picture where your symptoms are

How often do you have this symptom? _____ constant or intermittent? _____

If you have pain, what type of pain is it? (circle one) Sharp Dull Throbbing Numbness Aching
Shooting Burning Tingling Stiffness Swelling Other _____



Does it interfere with your (circle one) Work Sleep Daily Routine Recreation Sitting Standing Walking Bending Lying Down

Have you ever had treatment for this condition before? **Y N** If yes, by whom / when? _____

Have you ever been to a Chiropractor before? **Y N** If yes, whom / when? _____

Please turn over

HEALTH HISTORY

Please circle any symptom/condition which you have now, or have had in the past:

A.D.H.D
Aids/HIV
Alcoholism
Allergies
Anemia
Appendicitis
Arthritis
Asthma
Back pain
Bed-wetting
Bleeding disorders
Breast conditions
Breathing problems/Sinus
Bronchitis
Cancer
Cataracts
Chemical dependency
Chest pain
Chicken Pox
Cold hands/feet
Cold sweats/fever
Colic
Colon problems
Concussion
Constipation/diarrhea
Depressed immune system

Depression
Diabetes
Digestive problems
Dizziness
Ear fluid/infections
Ears ring/buzzing
Eating disorders
Emphysema
Epilepsy
Face seems flushed
Fainting
Fatigue
Fractures
Glaucoma
Goiter
Gonorrhea
Gout
Growing pains
Head seems heavy
Headaches
Hearing problems
Heart condition
Heartburn
Hepatitis
Hernia
Herniated disc

Herpes
High blood pressure
High cholesterol
Hyperactivity
Infertility
Irritability
Kidney disease
Light hurts eyes
Liver disease
Loss of balance
Measles
Memory loss
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Neck pain/stiffness
Nervousness/tension
Numbness
Osteoporosis
Pacemaker
Parkinson's Disease
Pinched Nerve
Pins and needles
Pneumonia
Polio

Poor posture
PMS
Prostate problems
Prosthesis
Psychiatric disorder
Reflux
Rheumatoid Arthritis
Rheumatic Fever
Ringing in the ears
Scarlet Fever
Scoliosis
Shortness of breath
Skin disorder
Sleeping problems
Stomach problems
Stroke
Suicide attempt
Thyroid problems
Tonsillitis
Tuberculosis
Tumors/growths
Typhoid fever
Ulcers
Vaginal infections
Visual problems
Whooping Cough

If you have a family history of any of the above, please list them here _____

Are you pregnant? **Y N** Due date _____ Pregnancy related symptoms? _____

BIRTH HISTORY
Length of labor and delivery? _____
Were any of the following used for delivery? (Please circle)
Forceps Vacuum C-section Breech Delivery
APGAR Score _____
Breast feeding bottle feeding

EXERCISE HISTORY
(Please circle one)
None
Moderate
Daily
Heavy
What type of exercise? _____

WORK ACTIVITY
(Please circle one)
Sitting
Standing
Light Labor
Heavy Labor
Hours per day _____
Days per week _____

HABITS
Smoking (Packs /day) _____
Alcohol (drinks /wk.) _____
Coffee/caffeine/day _____
High stress level _____
Nutrition? _____
How many glasses of water do you drink per day? _____

Injuries/surgeries/medications	Description	Date
Falls /Accidents (auto or personal)	_____	_____
Head injuries	_____	_____
Broken bones/dislocations	_____	_____
Surgeries	_____	_____
Medications	_____	_____

Signature of patient (or guardian if minor) _____ **Date** _____