



# Enfield Health and Wellness Center

Date \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Martial Status: M S W D

Work Telephone ( ) \_\_\_\_\_ # Children \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Cellular Telephone ( ) \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Email Address \_\_\_\_\_

Occupation \_\_\_\_\_

## HEALTH INFORMATION

Main Complaint \_\_\_\_\_

Have you had previous chiropractic care? Yes No Date \_\_\_\_\_

Have you had previous physical therapy? Yes No Date \_\_\_\_\_

Other Complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had similar conditions in the past? \_\_\_\_\_

Does this condition affect your work? Yes No

Does this condition affect your family or social life? Yes No

What aggravates this condition? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Are you taking any medication? Yes No If yes, please list \_\_\_\_\_

What helps your symptoms? \_\_\_\_\_

Have you had: Surgery? Yes No Falls? Yes No Accidents? Yes No

When? \_\_\_\_\_ Please describe \_\_\_\_\_

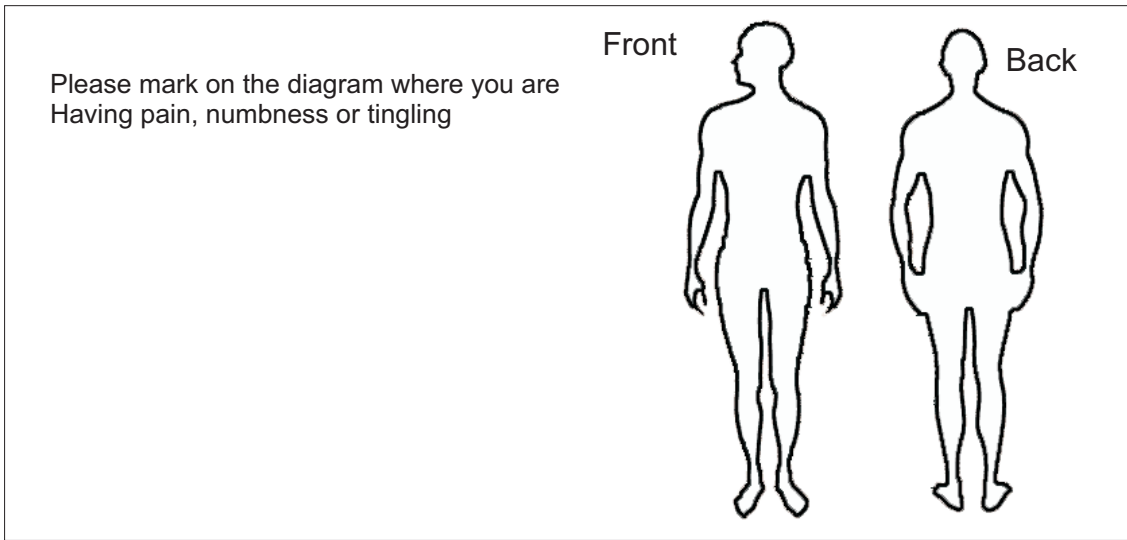
\_\_\_\_\_ Date of last physical examination \_\_\_\_\_

Who is your Primary Care Physican? \_\_\_\_\_

Are you Pregnant? Yes No

### Please check conditions or symptoms you currently have or have had in the past:

- Abdominal Pain
- Anemia
- Arm or Shoulder Pain
- Arthritis: *rheumatoid, gout, osteoarthritis*
- Back Pain
- Bladder Problems
- Cancer
- Chest Pain
- Circulatory Problems
- Constipation
- Depression
- Diabetes
- Digestive Disorder
- Dizziness
- Fatigue
- Fractures
- Headaches
- Heart Problems
- High or Low Blood Pressure
- Hip or Leg Pain
- Hot Flashes
- Immune System Problems
- Insomnia
- Kidney Problems
- Liver/Jaundice/Hepatitis
- Loose Stool
- Lung or Bronchial Disorder
- Memory Problems
- Menstrual Problems
- Metal Implants
- Neck Pain
- Nervousness
- Neurological: *Strokes, Seizures*
- Numbness
- Osteoporosis
- Palpitations
- Prostate Disorder
- Sinus Problems
- Swollen Joints
- Thyroid
- Visual Problems



## INSURANCE INFORMATION

Is this condition due to:

A work related injury? Yes No An automobile accident? Yes No

Do you have Health Insurance? Yes No Medicare # (if applicable) \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

Policyholder \_\_\_\_\_ Employer \_\_\_\_\_

Group# \_\_\_\_\_ ID# \_\_\_\_\_

Complete only for:

## JOB INJURY INFORMATION

Date \_\_\_\_\_ Time \_\_\_\_\_

Location \_\_\_\_\_ Description of accident \_\_\_\_\_

Worker Compensation Case # \_\_\_\_\_ Worker Compensation Insurance Carrier Claim # \_\_\_\_\_

Worker Compensation Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_

Employer's name \_\_\_\_\_ Address \_\_\_\_\_

Hospitalized? Yes No Name of Hospital \_\_\_\_\_ X-rays taken? \_\_\_\_\_

Other Doctors seen \_\_\_\_\_

Time lost from work (dates) \_\_\_\_\_ to \_\_\_\_\_

Complete only for:

## ATTORNEY INFORMATION

Have you lost any days of work? Yes No Dates \_\_\_\_\_

Insurance Companies Involved -Your Company \_\_\_\_\_

Other Companies \_\_\_\_\_

Have you been contacted by an insurance adjuster or  
company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this case? Yes No

Attorney Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

## TYPES OF CARE

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it.

Corrective Care: Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem.

Check here if you want the Doctor/Physical Therapist to select the type of care appropriate for your condition.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to the Enfield Health and Wellness Center and be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_