

# Slaymaker Chiropractic, P.C.

1803 First Ave SE \* Cedar Rapids, IA 52402 \* 319-363-2566 \* [www.slaymakerchiropractic.com](http://www.slaymakerchiropractic.com)

## Confidential Patient Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Marital Status  Single  Divorced  Widowed  Married Spouse Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

SSN \_\_\_\_\_ Patient Height \_\_\_\_\_ Patient Weight \_\_\_\_\_

Any Serious Illness? \_\_\_\_\_ Surgery/Date \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_ Other Doctor's Seen \_\_\_\_\_

Primary interest in  Wellness Care  Pain Management

What medications are you currently taking? \_\_\_\_\_

Do you use tobacco?  Yes  No Allergies \_\_\_\_\_

Have you suffered from any of the following?

- |                                    |  |  |                                    |  |
|------------------------------------|--|--|------------------------------------|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Bulging Disc  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neuritis            |
| <input type="checkbox"/> Numbness  | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> STDs          | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Tuberculosis        |

Referred by: \_\_\_\_\_

Do you have insurance that covers chiropractic? \_\_\_\_\_

## Financial Policy

All care in our office is provided on a fee for service basis. It is preferred that when a service is rendered- payment is made in full. You are responsible to this office for payment; however, we will be glad to file your insurance claim upon completion of treatment for your insurance reimbursement. Also, any checks returned for insufficient funds or accounts(\*) that have not been paid in full after 120 days will be charged a \$20 fee and will be turned over to a collection agency.

## Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

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

# Symptom Questionnaire

This information will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. The doctor will go over the questions with you when completed.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Where are you having your major problems?

- Head     Neck     Lower Back     Between shoulder blades  
 Shoulder     Hip     Other \_\_\_\_\_

How long has this condition lasted? \_\_\_\_\_

Is this condition...

- Getting Worse     Same     Improving

Briefly describe the initial cause of this condition (injury, accident, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What time of day is the pain worst?

- Morning     Evening     Night     All the time

Do you have pain in?

- Legs     Feet     Arms     Hands

Do you have numbness/tingling or pins and needles in?

- Legs     Feet     Arms     Hands

What makes the pain worse? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

Does the pain affect your sleeping?

- No     Occasionally     Frequently     Constantly

Does the pain affect your work?

- No     Occasionally     Frequently     Constantly

Have you been hospitalized in the last 5 years? If yes, for what? \_\_\_\_\_

Have you had major surgery in the last 5 years? If yes, for what and when? \_\_\_\_\_

Have you seen other doctors for this condition? If so, whom? \_\_\_\_\_

Have you ever seen a chiropractor before? If yes, whom? \_\_\_\_\_