Welcome to Quantum Chiropractic and Daniel B. Flemming, D.C.

Personal Information

Name: ____ Date: ____________
First Last MI
Birthdate: _________________ Age: _______ Male/Female SS#: __________________
Mailing Address: ___________________________ City: _________________________
State: _____________ Zip: ______________
Home Phone: ____________________ Work/Cell/Other Phone: ____________________
E-mail address: ____
Alt. E-mail ____
How did you hear about us? ____
Occupation: ______________________________
Status: Minor Single Married Divorced Widowed Spouse's Name: _____________
Do you have children? Yes No How many? ________

Reason for Visit

The reason for this visit is: ____
____
Please describe the pain and location: ____
____
When did it begin? _______________ Is it getting worse? Yes No Constant Comes/goes
Is this condition the result of a work related injury or Auto accident? Yes No
Is this condition interfering with your daily routine? Yes No If yes, please explain:
____
Have you had similar symptoms in the past? Yes No If so, please explain:
____
What makes it better?
____
What makes it worse?
____

Have you ever been treated by a Chiropractor? Yes No
If so, whom? ___________________________ Address or phone: ___________________
Any additional information you would like to include: _________________________________
____

Health History

Are you currently taking any medications? Yes No
If so, what? ____
If you have had any of the following conditions, please circle:
Heart Attack Stroke Cong. Heart Defect Alcohol Abuse
HIV+ Neck Pain High Blood Pressure Drug Abuse
Aids Headaches Low Blood Pressure Shingles
Fainting Seizures Epilepsy Diabetes Type I
Low Back Pain Emphysema Glaucoma Diabetes Type II
Psychiatric Problems Sinus Problems Artificial Valves Cancer
Anemia Ulcers Asthma Arthritis

Health History Continued
Please list any medical conditions or surgeries you have had with dates:
____

____

Family Health History:
____
Do you take supplements or vitamins? Yes No
If so, what: ____
What is your typical exercise routine? ____
Are you on a special diet? Yes No If so, what is it? _______________________________
Do you smoke? Yes No How much? ______________ How Long? ___________________
For women: Are you taking Birth Control? Yes No
Are you pregnant? Yes No How long? ________________ Nursing? Yes No

In Event of Emergency
Who should we contact? ____
Relationship to you? ____
Home Phone: _________________________ Work/Cell/Other Phone: _____________________
Who is your Medical Doctor? ____________________________ Phone: ____________________

We invite you to discuss with us any questions regarding our services.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front desk. We do not allow balances of more than $100 on any non-insurance (cash) case. Balance must be paid before further care is rendered

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ____ Date: ___________________