Choice Chiropractic & Wellness Center

Jonathan D. Schnelle, D.C.
3405 Penrose Pl., Suite 205, Boulder, CO 80301
(303) 442-2126 Fax (303) 444-0665

PATIENT INFORMATION/APPLICATION FOR CARE

(The following information is needed to better serve you. Please complete all questions.) **PLEASE PRINT or TYPE.**

Date: _____ Name: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ ☐Male ☐Female Your SS#: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Occupation: _____ Employer: _____ Years on job _____

Employer Address: _____City: _____ State: _____ Zip: _____

Driver License. # _____ Insurance Company _____

Do you have Medicare? ☐Yes ☐No Medicaid? ☐Yes ☐No

Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Minor Children: ☐ Yes ☐ No How many? _____

Spouse's name: _____ Birth date: _____ Age: _____

Spouse's occupation: _____ Employer: _____

Years on Job _____ Work phone: _____

How payment will be made: ☐Cash ☐Check ☐Credit Card ☐Health Insurance ☐Auto Ins. Policy ☐Workman's Comp.

Have you ever been in an Auto Accident? ☐Past year ☐Past 5 Years ☐Over 5 Years ☐Never

How did you hear about us? : _____

REASON FOR YOUR VISIT

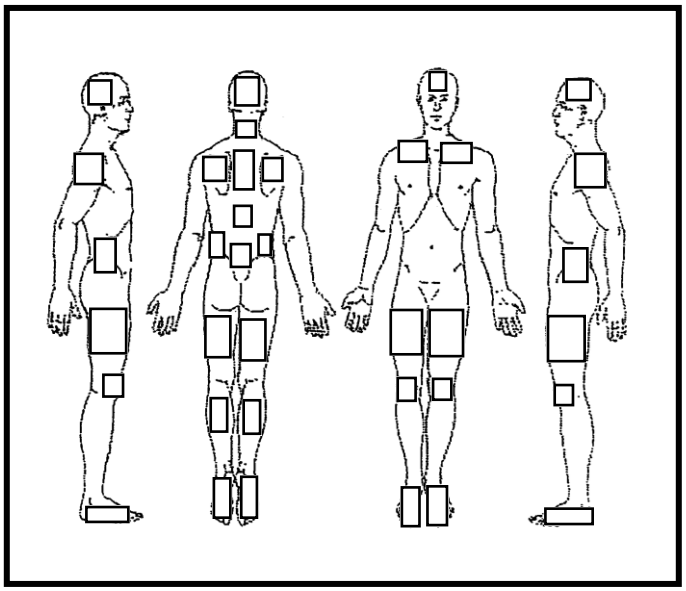
COMPLETE THESE DIAGRAMS

Please mark the exact location of your pain on the adjacent diagram. Also, describe the type, frequency, as well as any activity that brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

Major Complaints

(Please list any condition(s) you are experiencing.)

MARK LOCATION(S) OF PAIN BELOW AFTER PRINTING FORM



EMERGENCY CONTACT

Who should we contact: _____ Relation: _____

Cell Phone: _____ Work Phone: _____

Who is your Medical Doctor? Phone:

HEALTH HISTORY

CHECK any of the following diseases, medical conditions or procedures that you have or have had in the past:

☐Alcohol/Drug abuse	☐Dizziness	☐High/Low blood pressure	☐Osteoporosis	☐Ulcers
☐Allergies	☐Epilepsy/Seizures/Fainting	☐HIV / AIDS	☐Pacemaker	☐Upper back pain
☐Anemia/Diabetes	☐General muscle fatigue	☐Implants/Artificial joints	☐Polio	☐Venereal Disease
☐Arthritis	☐Glaucoma	☐Joint swelling/stiff	☐Rheumatic Fever	☐Psychiatric problems
☐Asthma	☐Gout	☐Kidney problems	☐Shingles	☐Birth Control
☐Cancer	☐Headaches	☐Low back pain	☐Shoulder pain	☐Hormone replacement
☐Congenital Heart Defect	☐Hepatitis	☐Mid-back pain	☐Stroke/Heart attack	**Currently Pregnant**
☐Congestive Heart Failure	☐Herniated Disc	☐Neck pain	☐Tuberculosis	☐Yes ☐No DUE: ____

OTHER: _____ ☐ **Check If None**

List Current Medications/Supplements: ☐ **Check If None** _____

_____

List Past Surgeries/Accidents, etc: ☐ **Check If None** _____

_____

LIFESTYLE HISTORY

Exercise: ☐YES ☐NO _____ Hours/Week

Tobacco Use: ☐YES ☐NO How Long? _____ _____ Packs/Week

Smokeless Tobacco Use: ☐YES ☐NO _____ Cans/Week

Alcohol Use: ☐YES ☐NO _____ Drinks/Week

Do you drink 8 (8oz) Glasses of Water Daily: ☐YES ☐AT LEAST ☐NO

I, the undersigned, do hereby attest that this questionnaire has been completed truthfully and to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information I have provided. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that insurance policies are a contract between the insurance company and the policy holder, not the doctor, and as such I am responsible to know any policy limitations that might exist. On all insurance assignments the deductible, if applicable, must be met first unless prior arrangements are made. Further, if the services of a collection agency become necessary to collect the balance on my account, any associated fees are my responsibility.

Patient's signature: _____ Date: _____

Or Guardian's signature: _____ Date: _____

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

REV 5/17

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