COMPLETE CHIROPRACTIC, LLC 5151 Post Road, Suite 150, Dublin, Ohio 43017 Phone (614) 798-9600 Fax (614) 798-0021

Name: _____ **SSN:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home: _____ **Work:** _____ **Cell:** _____ **E-Mail:** _____

Work Status: ___Employed ___Home ___Student **Marital Status:** ___Married ___Single

Referred By: Name: _____ **Provider Book** ___ **Family Dr.** ___ **Newspaper** ___
Yellow Pages: Columbus ___ **Northwest** ___ **Dublin** ___ **Christian Pages** ___

Family Doctor's Name: _____ **May we forward notes?** _____

What type of exercise do you perform? __ None __ Light __ Moderate __ Strenuous

What is your height and weight? Height: Feet ____ **Inches** _____ **Weight:** _____ **lbs.**

For each of the following condition listed below, place a check in the appropriate column.

Past	Present		Past	Present		Past	Present	
__	__	Headaches	__	__	High Blood Pressure	__	__	Diabetes
__	__	Neck Pain	__	__	Heart Attack	__	__	Excessive Thirst
__	__	Upper Back Pain	__	__	Chest Pains	__	__	Frequent Urination
__	__	Mid Back Pain	__	__	Stroke			
__	__	Low Back Pain	__	__	Angina	__	__	Smoking/Use Tobacco Products
__	__	Shoulder Pain	__	__	Kidney Stones	__	__	Drug/Alcohol Dependence
__	__	Elbow/Upper Arm Pain	__	__	Kidney Disorders	__	__	Allergies
__	__	Wrist Pain	__	__	Bladder Infection	__	__	Depression
__	__	Hand Pain	__	__	Painful Urination	__	__	Systemic Lupus
			__	__	Loss of Bladder Control	__	__	Epilepsy
__	__	Hip/Upper Leg Pain	__	__	Prostate Problems	__	__	Dermatitis/Eczema/Rash
__	__	Knee/Lower Leg Pain	__	__	Abnormal Weight Gain/Loss			
			__	__	Loss of Appetite	***FEMALES ONLY***		
__	__	Jaw Pain	__	__	Abdominal Pain	__	__	Birth Control Pills
__	__	Joint Swelling/Stiffness	__	__	Ulcer	__	__	Hormonal Replacement
__	__	Arthritis	__	__	Hepatitis	__	__	Pregnancy
__	__	Rheumatoid Arthritis	__	__	Liver/Gall Bladder Disorder	__	__	
__	__	General Fatigue	__	__	Cancer	***OTHER HEALTH PROBLEMS/ISSUES***		
__	__	Coordination Problems	__	__	Tumor	__	__	
__	__	Visual Disturbances	__	__	Asthma	__	__	
__	__	Dizziness	__	__	Chronic Sinusitis	__	__	

Indicate if an immediate family member has had any of the following:
___ **Rheumatoid Arthritis** ___ **Heart Problems** ___ **Diabetes** ___ **Cancer** ___ **Lupus**

List all prescriptions and over-the-counter medication, nutritional/herbal supplements you are taking:_____

List all surgical procedures you have had and times you have been hospitalized:

_____

I Understand & agree that health & accident insurance policies are an arrangement between myself & my insurance company, not between my insurance company & this office. **I authorize this office to release any medical information & to complete any usual & customary reports & forms to assist in collecting payment from my insurance. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full. I also understand that if I suspend or terminate my schedule of care as determined by my treating physician, any fees will be immediately due. My underlying signature also serves as consent for treatment recommended by the physician unless otherwise noted.**

Patient / Guardian Signature: _____ **Date:** _____