Guarino Chiropractic

"Misson Statement"

We welcome you as a patient and appreciate the opportunity to provide you with the best quality chiropractic care. Our goal is to make you healthy, happy and wise. Using the latest chiropractic information and technology, we will strive to maintain the highest level of integrity and personal commitment to our patient's healthcare needs. With true sincerity we help and guide people by educating the public about the art, science, philosophy and benefit of chiropractic care to achieve optimal health. We believe changing lives through chiropractic is our purpose...
Touching lives is our gift.

Please Print Clearly and fill in completely.

Print Name:_____ **Your SSN:**____-____-_____

Street Address: _____ **Phone:** _____

City: _____ **State:** ____ **Zip:** _____ **Date of Birth:**_____

e-Mail: _____ **Emergency Contact & Phone:**_____

Employer's Company Name:_____ **Employer's Work Phone:**_____

Please Check ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑ Married❑ Single❑

Health History:

Give reason for seeking chiropractic care: _____

_____

Is this related to an automobile accident or job related injury? Yes❑ No❑ If "Yes", which:_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, please list the doctors you are seeing, the conditions being treated for, and your progress to date.

_____

_____

List any current Medications: _____

List any past surgeries & dates:_____

List any past accidents & dates: _____

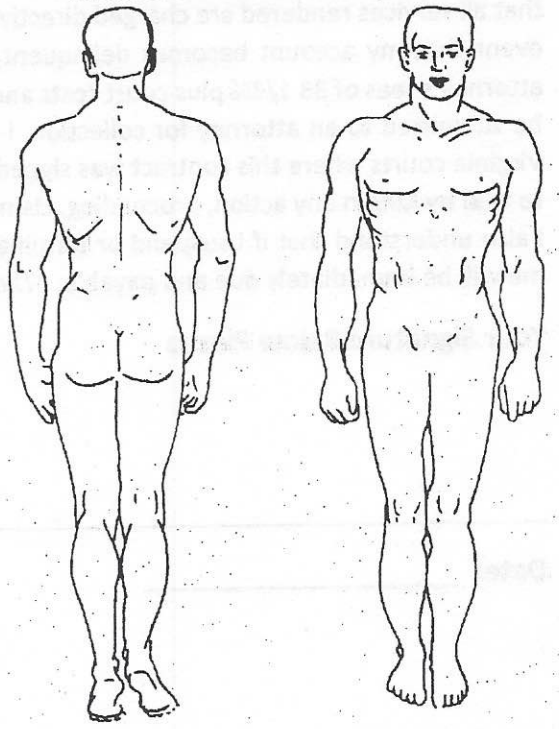
Do you smoke tobacco? Yes❑ No❑ If Yes, what type and how often :_____

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	☐	☐
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other joint pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems	☐	☐
Vision Changes	☐	☐
Nose Bleeds	☐	☐
Ringing in Ears	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Cough	☐	☐
Chest pains	☐	☐
Female problems	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Digestive problem	☐	☐
Urinary Problems	☐	☐
Frequent colds	☐	☐
Skin conditions	☐	☐
Other _____	☐	☐

Circle the areas where you have any problems.
Please also describe these problems.



Patient's Insurance Information:

Insurance Company Name:_____ Phone:_____

ID Number:_____ Group Number:_____

Subscriber's Name:_____ Subscriber's Date of Birth:_____

Subscriber's SSN:____-____-_____

Personal & Family History:

Your Occupation: _____ Work Duties_____

Spouse's name:_____ Date of Birth:_____ Health status:_____

Spouse's Work Phone:_____ Spouse's Employer:_____

Family Health Information: (Many health problems are the result of hereditary spinal weaknesss: thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name_____

Date of last chiropractic visit _____ Reason for care_____

Date of last chiropractic x-rays_____ How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who? _____

Wellness Commitment

At Guarino Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%-------- 20% --------30%-------- 40% --------50%-------- 60% --------70%-------- 80% --------90% ------- 100%

Where did you hear about our clinic
or who referred you? _____

FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes❑** **No❑**

I understand and agree that health insurance is an arrangement between an insurance carrier and myself. I understand that the Guarino Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to this office will be credited to my account in a timely manner. However, I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. In the event that my account becomes delinquent, I will be responsible for all costs of collection including attorney's fees of 33 1/3% plus court costs and interest at the rate of 18% per annum. Should this matter be submitted to an attorney for collection, I agree to submit to the jurisdiction of the Henrico County, Virginia courts where this contract was signed. Further, by my signature below, **I hereby waive my right to trial by jury** in any action, proceeding, claim or counterclaim related to or arising from this agreement. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. *Thank you for being complete and thorough.*

Your Signature Below Please

_____

Date: _____