Welcome to Marion Family Chiropractic

Today's Date _____

Name _____ Home phone _____

Mailing Address _____

Town _____State _____ Zip _____

Business Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Age _____ Social Security # (optional) _____

Marital Status _____ Name of Spouse/Partner _____

Names and Ages of Children _____

Occupation _____ Employer _____

Business Address _____

Town _____ State _____ Zip _____

Reason for consulting this office (check all that apply):

- □ Wellness and Preventive Care
- □ Specific pain and/or health problems (please explain)

_____

Overall, what do you perceive as your current health problems? _____

_____

Please list any prescription/non-prescription medications you are taking : _____

_____

Please list previous surgeries and hospitalizations, with dates:

_____

Have you or your family had previous chiropractic care? □ Yes, I have □ Yes, my family member □ No

If you have had chiropractic care, when was your last visit? _____

How long did you receive care? _____ If you stopped, why did you stop? _____

Do you know what technique was used? _____ Were you pleased with your care? _____

(*please turn over*→)

How did you learn about this office?

□ Personal referral □ Sign □ Health Fair/Lecture □ Employer □ Wanderer

□ Google □ Insurance Provider □ Social Media □ Other _____

If you were referred, please note their name so we may personally thank them:

_____

Demographic Data Our Federal Office of Management and Budget (OMB) has asked that we collect the following Data. No personal information is associated with this data when we send it to OMB.

Race:
□ American Indian or Alaskan
□ Asian
□ Black or African American
□ Native Hawaiin or Other Pacific Islander
□ White
□ Other Race
□ Declined

Ethnicity:
□ Hispanic or Latino
□ Not-Hispanic or Latino
□ Declined

Language:
□ Arabic □ Cantonese □ English □ French □ German □ Hindi □ Italian
□ Japanese □ Korean □ Mandarin □ Other □ Persian □ Polish □ Portuguese
□ Romanian □ Russian □ Spanish □ Tagalog □ Ukrainian □ Urdu □ Vietnamese

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Name of person responsible for account _____

Signature _____ Date _____

If you expect insurance to contribute to your care, or would like us to check for your chiropractic coverage, please provide your insurance card and subscriber's name, address, date of birth and sex

Insurance Subscriber Name _____ DOB __/__/_____

Complete Address _____ Sex __M __F

Your attitude about your health is important to us. Below are four prevalent health attitudes. Please mark the one that most closely reflects your personal values:

□ Treatment only. You only consult a doctor when you have an ache or a pain and discontinue treatment as soon as it has cleared up.

□ Prevention. In addition to symptomatic treatment, you consult specialists occasionally to prevent problems from recurring.

□ Maintaining health. You are conscious about your health, diet, exercise, etc. and actively pursue these because you feel better, perform better, and it maximizes your potential.

□ Family health. You take an active part in assisting, informing, and maintaining health with your family. You are concerned with the long term affects of good health.

Thank you. We look forward to providing your chiropractic care.

Dr. Jennifer F. Eames
Dr. Belinda L. Marcil