# Omer Chiropractic
## Lifestyle Center
*"Creating Healthier Tomorrows"*

Welcome to Omer Chiropractic Lifestyle Center. Thank you for choosing our office for your chiropractic care. We are committed to providing you with the highest quality of chiropractic care available.
Following your paperwork, the doctor will discuss your health history and perform an examination. The acceptance of your case will be based on the examination and diagnostic findings. If you ever have any questions regarding your chiropractic care, please don't hesitate to ask us. We look forward to a long, healthy relationship with you and your family.

Today's date:_____

Name: _____Preferred name (if different): _____ SS#:_____

Email Address: _____ Date of Birth: _____ Age: _____ Gender: M / F

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Cell Phone:_____ Employer: _____ Work Phone:_____

Check One: □ Single □ Married □ Widowed □ Divorced □ Separated # of Children: _____

Spouse Name: _____ Phone: _____

Name of emergency contact: _____ Phone: _____

How did you hear about our office? (Whom may we thank for referring you to us?): _____

| List your problems or complaints according to severity: | Date started, or for how long? | If you had the condition before, when? | Did problem begin with an injury? |
|---|---|---|---|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |

Previous accidents and/or injuries: auto, work related, or other (especially those related to your present condition).

1. Type: _____ When: _____ Hospitalized? □ yes □ no
2. Type: _____ When: _____ Hospitalized? □ yes □ no
3. Type: _____ When: _____ Hospitalized? □ yes □ no

NOTE: If you have RECENTLY been involved in an accident or injury, please inform a staff member so they may bring you our accident report form.

Have you had any surgery? (Please include all surgery)

1. Type: _____ When: _____ Doctor: _____
2. Type: _____ When: _____ Doctor: _____
3. Type: _____ When: _____ Doctor: _____

Have you had any x-rays taken?

When? _____ Where? _____ Area of Body: _____

Have you been under chiropractic care before? □ Yes □ No Date of your last visit: _____

If so, Chiropractor's name: _____

FEMALES ONLY: Date of last menstrual period?_____ Are you pregnant? □ Yes □ No □ Maybe

PERSONAL HISTORY:

Any medical conditions you have been diagnosed with?_____

Medications: _____

Allergies: _____

WHY CHIROPRACTIC??? People seek chiropractic care for a variety of reasons. Some want symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health and wellness possible with chiropractic care (Wellness Care). Your Doctor will weigh your needs and desires when recommending your treatment.

Please check the type of care desired so we may be guided by your wishes whenever possible.

□ Relief Care □ Corrective Care □ Wellness Care □ Check here if you want the Doctor to select the type of care appropriate for your condition

Our office policy requires payment in full for all services rendered at the time of the visit. We do not file your insurance, however we will provide you with all the necessary information to submit it yourself. We invite you to discuss any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider (our office) and the patient (you).

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

Signature: _____ Date: _____

Guardian Signature (if minor) : _____