

WELCOME

The Doctors and Team of Ottawa Chiropractic Clinic wish to welcome you on your first visit to our office. Our purpose is to provide you, your loved ones and friends the best health and wellness experience possible.

On this first visit we look forward to meeting you and learning about your health challenges. We will make the time and the effort to listen to you and your concerns. Together we will form a plan to help you achieve your health and wellness goals.

To help us assist you in reaching these goals we will need information. The next few pages will help provide us with information needed to serve you. After you have completed your health intake and history form, your doctor will meet with you to discuss your challenges and conditions.

Thank you for choosing Ottawa Chiropractic Clinic for your health and wellness needs. We look forward to meeting you and are excited to be a part of your health care team. Together we will accomplish miracles.

The Doctors and Team of Ottawa Chiropractic Clinic

**OTTAWA CHIROPRACTIC CLINIC
HEALTH HISTORY**

Name: _____ Date: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

SS#: _____ Birthday: _____

Occupation: _____ Employer: _____

Work Phone: _____ Address: _____

City/State: _____ Zip: _____

Spouse: _____ Children (Name & Ages) _____

E-Mail Address: _____ Who referred you to us? _____

Past Chiropractic Care? Yes / No Why? _____

Current Drugs/Medication: _____

Please check the options that apply to you:

- I am only concerned about relief of a particular symptom.
- I am only concerned about relief of a particular symptom, and preventing its return.
- I want optimum health and wellbeing on every level available to me.
- I would like to schedule an appointment for my family members to have their spines and nerve systems checked.

Reasons for consulting our office:

1. _____

2. _____

THE POWER OF THE BODY

The human body is designed to express health and function normally.
However, events may occur in life, which can interfere with this natural ability.
This interference is most commonly caused by **vertebral subluxations**, resulting from
physical, chemical or emotional stress. The practice of **chiropractic** is based on
locating and reducing the vertebral subluxation, which causes nerve system interference.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following...→

PLEASE COMPLETE THE BACK OF THIS PAGE

PLEASE TELL US ABOUT ANY STRESS AT YOUR BIRTH:

	NO	YES	EXPLAIN:
1) Drugs/medicine/tobacco/alcohol in pregnancy?	___	___	_____
2) Labor chemically induced?	___	___	_____
3) Forceps/Vacuum Extraction/C-section	___	___	_____
4) Premature delivery?	___	___	_____
5) Vaccinations?	___	___	_____
6) Falls in first year of life?	___	___	_____
7) Any health related problems?	___	___	_____

PLEASE TELL US ABOUT ANY STRESS RELATED TO YOUR CHILDHOOD:

	NO	YES	EXPLAIN:
1) Any falls or injuries?	___	___	_____
2) Allergy/Asthma or Respiratory	___	___	_____
3) Ear infections?	___	___	_____
4) Digestive problems?	___	___	_____
5) Hyperactivity?	___	___	_____
6) Any other health related problems?	___	___	_____

PLEASE TELL US ABOUT ANY STRESS UP TO PRESENT:

	NO	YES	EXPLAIN:
1) Auto Accident or Injury?	___	___	_____
2) Work Injury?	___	___	_____
3) Sports Injury?	___	___	_____
4) Work Stress?	___	___	_____
5) Family / Home stress?	___	___	_____
6) Prescription Drug use?	___	___	_____
7) Non-Prescription Drug use?	___	___	_____
8) Ever Hospitalized?	___	___	_____
9) Surgery?	___	___	_____
10) Any Major Illness?	___	___	_____
11) Reoccurring Illnesses?	___	___	_____
12) Limited Exercise?	___	___	_____
13) Poor Nutrition?	___	___	_____

**WE ACCEPT MOST INSURANCE POLICIES AS WELL AS PAYMENT BY CASH,
CHECK AND CREDIT CARD**

I understand that all services are to be paid in full at the time of service,
unless other arrangements have been made and agreed upon in writing.

AUTHORIZATION FOR CARE

I hereby authorize the Doctor(s) to work with my condition through use of adjustments, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Signature _____ Date _____