

**ESTRAMONTE CHIROPRACTIC & WELLNESS CENTER, P.A.**  
**ESTRAMONTE CHIROPRACTIC & WELLNESS CENTER, EAST, P.A.**

Name \_\_\_\_\_ Sex:  Male  Female  
Last First Middle  
Do you prefer to be called:  First Name /  Nick Name \_\_\_\_\_ or  Mr.  Mrs.  Miss  
Marital Status:  Married;  Single;  Widowed;  Divorced;  Separated  
Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
Street/Route # Apt # City State Zip Code  
E-mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone Number \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Street City State Zip Code

Spouse's Name \_\_\_\_\_  
Spouse's Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_ Phone Number \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Street City State Zip Code

Person to contact in case of emergency \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_  
Nearest relative not living with you \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

I certify that the above statements are true to the best of my knowledge.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES  
YOUR CURRENT GOALS FOR HEALTH / WELLBEING.

- 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.

WE ACCEPT 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 RELEASE OF INFORMATION AND PAYMENT OF MEDICAL BENEFITS

I understand I am financially responsible WHETHER OR NOT MY INSURANCE COMPANY PAYS for all charges incurred by me. I hereby assign all medical payments to Estramonte Chiropractic & Wellness Center, P.A./Estramonte Chiropractic & Wellness Center, East, P.A. Any overpayment will be promptly refunded. I authorize the release of any medical information needed to process my insurance claims. I agree to pay all collection costs, court costs and attorney's fees in addition to my charges. Further, I give this office Power of Attorney to endorse checks made out to me, to be credited to my account. I understand that I am subject to a credit check before having credit extended to me.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# Estramonte Chiropractic

## Initial Current Health History

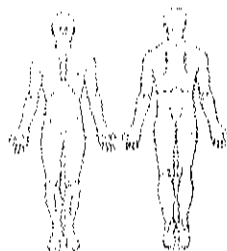
NAME \_\_\_\_\_

CHART # \_\_\_\_\_

DATE \_\_\_\_\_

**1**

What is your major symptom / problem?



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical State	Never	→	Always
Physical Pain/Tension/Stiffness	1 2 3 4 5		
Difficulty Sleeping	1 2 3 4 5		

Mental/Emotional State	Never	→	Always
Experience of Fears/Anxiety	1 2 3 4 5		
Experience of Depression	1 2 3 4 5		

Life Enjoyment	Terrible	→	Great
Your Personal Life	1 2 3 4 5		
How You Feel About Yourself	1 2 3 4 5		

Overall Quality of Life	Terrible	→	Great
Your Personal Life	1 2 3 4 5		
Your Life as a Whole	1 2 3 4 5		

**2**

What other treatments have you had for this condition?

- Chiropractic  
  Orthopedic  
  Neurologist  
  Physical Therapy  
 Medication  
  Surgery  
  Other \_\_\_\_\_

Previous Chiropractic Care?  No  Yes—Date: \_\_\_\_\_

Out of State  Local \_\_\_\_\_

List any medications you are taking:

\_\_\_\_\_

Vitamins / Herbs / Minerals \_\_\_\_\_

Describe the physical requirements of your Occupation:

\_\_\_\_\_

Describe your exercise level:

- None  
  Moderate  
  Daily  
  Heavy

Stressors:

- Smoking                      Packs / Day \_\_\_\_\_  
 Alcohol                         Drinks / Week \_\_\_\_\_  
 Caffeine Drinks                Cups / Day \_\_\_\_\_  
 High Stress Level               Reason \_\_\_\_\_

FEMALES

Are you pregnant?  Yes  No  Unsure

**3**

Check any of the following conditions you have had:

- |                                               |                                           |                                              |                                              |
|-----------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> AIDS / HIV           | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Arm / Shoulder Pain |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Bladder Problems    | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Deafness         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Digestive Problems  |
| <input type="checkbox"/> Earache              | <input type="checkbox"/> Ear Ringing      | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Headaches—Migraine   | <input type="checkbox"/> Herniated Disc   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Insomnia            |
| <input type="checkbox"/> Irregular Cycle      | <input type="checkbox"/> Kidney Problems  | <input type="checkbox"/> Leg Pain            | <input type="checkbox"/> Low Back Pain       |
| <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Poor Circulation    | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sciatica         | <input type="checkbox"/> Shingles            | <input type="checkbox"/> Sinus Infection     |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> TMJ Dysfunction     | <input type="checkbox"/> Vertigo / Dizziness |

Have you had any:

Automobile Accidents

Surgeries

Broken Bones

Falls / Head Injuries

DESCRIPTION

DATE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ESTRAMONTE CHIROPRACTIC & WELLNESS CENTER, P.A.**  
**ESTRAMONTE CHIROPRACTIC & WELLNESS CENTER, EAST, P.A.**  
**DBA: Keith Clinic of Chiropractic and Estramonte Wellness Center**  
**FINANCIAL POLICY**

We are committed to providing you with the best possible care. If you have medical insurance, we will do our best to help you receive your maximum allowable benefits. In order to achieve these goals, we need your understanding of our payment policy.

**INSURANCE:** Your insurance policy is a contract between you and your insurance company. Our professional services are rendered to you, not your insurance company. We will, as a courtesy to you, bill your insurance company. However, you will be responsible for all charges not paid by them. If your insurance policy does not provide chiropractic coverage or you do not want to file your insurance, you will be asked to pay on the day of the service. If you have a deductible, we ask that you pay in full for each visit until your deductible has been met. Co-payments are due at each office visit.

**SELF PAY: (NO INSURANCE)** We ask that self pay patients pay at each visit. If there is a financial hardship, you may make arrangements with one of our financial managers. In the event that you request a credit arrangement, our staff will do a credit check before arrangements are made.

**MEDICARE:** We do accept assignment of Medicare claims. Your co-insurance, as well as charges not covered by Medicare, are due at the time of service.

**AUTO INJURY/PERSONAL INJURY/WORKERS' COMPENSATION:** Please advise our office whenever you have one of the above claims. We will work with insurance companies/attorneys involved, but please remember that **you** are ultimately responsible for your bill if payment cannot be obtained from another party. Additional information will be provided to you if you will be filing one of the above claims.

I have read the above **FINANCIAL POLICY** and understand and will comply with the terms stated:

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Patient Signature

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Date of Signature

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Print Name

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Witness Signature