

PULSE CHIROPRACTIC CLINIC

**12325 Scarsdale Blvd.
Houston, Texas 77089**

Date: _____

Name _____

Address _____ City _____ ST _____ Zip _____

Age _____ Birthday _____ Marital Status: M S D W. How Many Children _____

Occupation _____ Employer _____

Home Number _____ Work Number _____

Cell Number _____ E Mail Address _____

Are you insured? Y or N Name of Insurance Co. _____

ID# _____ Grp# _____ Phone# _____

Please list your family physician. May we have your permission to contact them? Y or N

In Case of Emergency Please Contact _____ Phone# _____

Who referred you? _____ Date of Last Physical Exam _____

What is the reason for today's appointment?

What Medications are you taking? _____

List Surgeries _____

(WOMEN) Is there a possibility that you could be pregnant? Y or N

SPOUSE INFORMATION

Name of Spouse _____ Date of Birth _____

Employer _____ Phone # _____

AUTO ACCIDENT

My Auto Insurance Co. _____ Claim # _____

Adjuster's Name & Phone # _____ Date of injury _____

Time _____ Location _____

Please describe accident _____

Is there any other Insurance Co. Involved? Y or N Do you have an Attorney? Y or N

Yes, please list Name & Phone# _____

PAYMENT IS EXPETED AT THE TIME OF SERVICE

Person responsible for payment: _____

I understand and agree that health and accident insurance policies are an arrangement between them & me. I authorize Pulse Chiropractic Clinic to prepare and send the reports & forms needed in collecting any payments from my Insurance Co. or Attorney. I authorize payments to be made directly to: Pulse Chiropractic Clinic. If I change Insurance Companies or Attorney's during my treatment I am obligated to inform Pulse Chiropractic Clinic. I am aware that I am ultimately responsible for any and all balances due.

Patient Signature: _____

Date: _____

Guardian Authorizing Care: _____

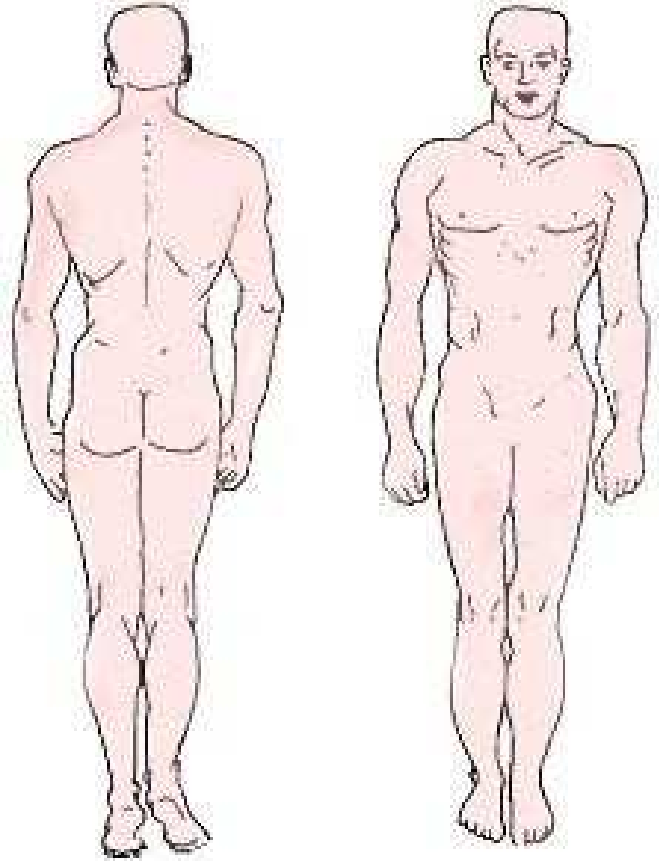
Date: _____

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	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Thank you for being complete and thorough.

Your Signature Below Please

Date: _____