BENOFF CHIROPRACTIC CENTER

607B Louis Drive Warminster, PA 18974 Telephone (215) 672-4700 // Facsimile (215) 672-2411

WELCOME TO OUR OFFICE. PLEASE COMPLETE BOTH SIDES OF THIS FORM.

PATIENT INFORMATION

Name_____ Date_____
Address_____
Street City State Zip
Home Phone_____ Mobile Phone (Optional)_____
Birthdate_____ Sex: □ M □ F Age_____ Occupation_____
Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced
SS#_____ Email address (Optional)_____

Your Employer_____ Work Phone_____
Employer Address_____
Street City State Zip

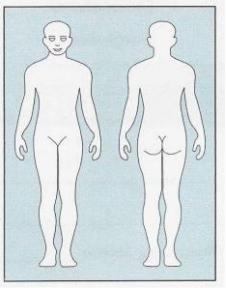
Health Insurance Plan_____ ID#_____
Policyholder's Name _____ Policyholder's Relationship___
Policyholder's Date of Birth_____ Policyholder's Employer_____

Please help us by indicating how you were referred to our office: □ Verizon Yellow Pages
□ Family/Friend (Name)_____ □ Physician (Name)_____
□ Insurance Network (Phone___Directory___Online___) □ Internet □ Other_____
In case of emergency, contact:
Name_____ Relationship_____ Phone_____

PATIENT CONDITION

Reason For Visit:_____
_____
Date problem began:_____ Is this □ Auto Related □ Work Related □ N/A

Mark an X on the picture to show areas of pain, numbness or tingling:



Rate the severity of your pain on a scale from 0 to 10:

0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

How often do you have this pain?_____
Is this condition getting progressively worse? □ Yes □ No □ Unknown
Type of pain: □ Sharp □ Dull □ Throbbing □ Shooting □ Burning
Do you have: □Burning □Tingling □Numbness □Swelling □Stiffness □ Other_____
Does your condition interfere with your □ Work □ Sleep □ Recreation □ Daily Routine
Do you have pain or discomfort □Sitting □Standing □Walking □Bending □Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? □ Surgery □ Physical Therapy □ Chiropractic Services
□ Medications □ None □ Other_____

Names and addresses of other doctors who have treated you for your condition:
_____

Please indicate if you have had any of the following tests: □ X-RAY □ MRI □ CT □ EMG □ BONE DENSITOMETRY
State approximate dates, testing facilities and areas examined:
_____

If female, are you pregnant? □ Yes □ No If yes, what is your due date?_____

Please check to indicate if you have had any of the following:

- □ AIDS/HIV
- □ Allergies
- □ Arthritis
- □ Alcoholism/Chemical Dependency
- □ Blood Clots/Bleeding Disorders
- □ Varicose Veins
- □ Diabetes
- □ Hepatitis
- □ Epilepsy
- □ Cancer
- □ Heart Disease
- □ Chest Pain/Shortness of Breath
- □ Stroke
- □ High/Low Blood Pressure
- □ High Cholesterol
- □ Dizziness/Fainting Spells
- □ Thyroid Problems
- □ Fatigue/Insomnia
- □ Kidney/Liver Disease
- □ Psychiatric Care/Severe Depression
- □ Back Pain
- □ Neck Pain
- □ Shoulder Pain/Bursitis
- □ Herniated Disc
- □ Sciatica
- □ Headaches
- □ Multiple Sclerosis
- □ Numbness in Hands/Feet
- □ Osteoporosis
- □ Stomach Disorders
- □ Other (Please Explain) _____

Family History: □ Cancer □ Diabetes □ High Blood Pressure □ Heart Disease/Stroke □None

EXERCISE	WORK ACTIVITY	HABITS	
□ None	□ Sitting	□ Smoking	Packs/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week _____
□ Daily	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason_____

Please indicate any surgeries, head injuries or broken bones you have had:

Date	Description
_____	_____
_____	_____
_____	_____

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE READ AND SIGN THE AUTHORIZATION BELOW

I have listed all my known medical conditions and physical limitations and I will inform my doctor of any changes in my physical health. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize my insurance benefits to be paid directly to Benoff Chiropractic Center.

I authorize the release of all medical information related to the services rendered.

Patient Name (Please Print)_____

Patient or Guardian (if applicable) Signature_____ Date_____