INDY HEALTH & WELLNESS CENTER

PATIENT INFORMATION FORM

PLEASE PRINT

PATIENT NAME	SEX: M F	DATE OF BIRTH	AGE
ADDRESS	PRIMARY PHONE ( )		
CITY	STATE	ZIP	
SOCIAL SECURITY	E-MAIL		
MARITAL STATUS: SINGLE	MARRIED	DIVORCED	WIDOWED LIFE PARTNER
OCCUPATION	EMPLOYER		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?			
SPOUSE OR PARENTS NAME	THEIR PRIMARY PHONE ( )		
SPOUSE OR PARENTS EMAIL			
NEAREST RELATIVE NOT LIVING WITH YOU		PHONE NO. ( )	
WHOM MAY WE CALL IN CASE OF EMERGENCY?		PHONE NO. ( )	
IF YOU HAVE INSURANCE FOR CHIROPRACTIC CARE PLEASE GIVE YOUR CARD TO THE FRONT DESK TO BE COPIED.			
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?			
	(Responsible party to sign here)		

IF INSURED/POLICY HOLDER) IS OTHER THAN PATIENT, PLEASE LIST SS#____________________

REASON FOR YOUR VISIT OR MAJOR COMPLAINT (symptoms)

____

____

IS YOUR VISIT DUE TO AN ACCIDENTAL INJURY? YES NO (If yes, explain briefly)

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____

PATIENT HISTORY INFORMATION

DATE OF LAST PHYSICAL EXAMINATION	
YOUR FAMILY PHYSICIAN	THEIR PHONE ( )
ARE YOU PREGNANT? YES NO DATE OF LAST MENSTRUATION:	

Do you have or have you ever been treated for (check all that apply):

Yes	No		Yes	No	
___	___	1. Heart Trouble	___	___	11 Hepatitis of any kind_____________
___	___	2. High Blood Pressure	___	___	12. Ulcers/Other Digestive Problems
___	___	3. Bleeding Disorder	___	___	13. Kidney/Bowel/Bladder Trouble
___	___	4. Stroke	___	___	14. Diabetes
___	___	5. Epilepsy/Seizures	___	___	15. Cancer_______________________
___	___	6. Fainting Spells/Dizziness	___	___	16. Fatigue/Malaise
___	___	7. Difficulty Breathing/Asthma	___	___	17. Drugs/Alcohol/Smoking
___	___	8. Abnormal Chest X-Ray/EKG	___	___	18 Depression, Anxiety or Eating Disorder
___	___	9. Pneumonia/Bronchitis	___	___	19 Significant Weight Loss/Gain
___	___	10. Thyroid/Hormonal Disorder	___	___	20. Allergies (please list)______________

Are you currently taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc.?

Yes No If yes, please list: ____

____

____

____

Have you taken other medications in the past? Yes No If yes, please list: ____________________________

____

____

Do you smoke or use any tobacco products? Yes No

Do you drink coffee, tea or other caffeinated drinks? Yes No

Do you drink sodas or energy drinks? Yes No

How many glasses of water do you drink every day? ___________

How often do you exercise? None Moderate Daily

Are there issues in your family history we should know about?

Mother____

Father____

Brother____

Sister____

Other____

List any surgeries and approximate dates ______________________________________

____

____

** I understand stand and agree that, regardless of my insurance status, I am ultimately responsible for the entire balance of my account. Payment is due at the time services are rendered unless payment arrangements have been approved in advance. Should legal action become necessary, I am responsible to pay for any attorney fees or collection agency fees required to collect the balance due on my account to which may be added interest at the current legal rate. I have read and understand all the information on this sheet and have answered the above questions correctly and truthfully to the best of my knowledge.

*****Indy Health & Wellness Center reserves the right to charge a fee for any scheduled visits that are:**

1) Cancelled with less than 24 hour notice
2) Missed without calling to cancel (No Show)

CANCELLATION FEE: $30

SIGNATURE ____DATE ____________

(or parent if patient is under 18 years old)

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