



LONGIE
CHIROPRACTIC
HEALTH CENTER

*Welcome to our office!
It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.*

DO YOU SUFFER FROM:

	YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problem	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

CHIROPRACTIC HEALTH QUESTIONNAIRE

Name _____ Home Phone _____
 Address _____ Work Phone _____
 City, State, Zip _____ Email Address _____
 Birthday _____ Age _____ SS# _____
 Occupation _____ Employer _____
 Martial Status: M W Sep. D Sin. Spouse Name _____ # of Children _____

- Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? _____
 Friend/Family Member Name _____
 Telephone Call Yellow Pages Sign Website Presentation E-mail
 Other _____
- Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ Never
- When was your last complete spinal examination including x-rays? _____ Never
- Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? YES NO
- Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? YES NO
- Spinal misalignment can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? YES NO
- Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent
- Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days. Low - 1 2 3 4 5 6 7 8 9 10 - High
- Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are your currently taking? _____
- Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?
 YES NO Date of incident _____
- Spinal health is especially important during pregnancy. Is there any chance that you are pregnant?
 YES NO
- If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations?
 YES NO
- Would you like to receive our health and wellness newsletter via e-mail?
 YES NO

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ Date _____

(If you plan to bill insurance for future service, please complete the back)

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, 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. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature _____

Date _____

Guardian or Spouse's Signature Authorizing Care _____

Date _____

Who should receive bills for payment on your account?

Patient

Spouse

Parent

Worker's Comp

Auto Insurance

Medicare

Medicaid

Personal Health Insurance

Ownership of X-ray Films:

It is understood and agreed that the payment to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at anytime while I am a patient of this office.

ABOUT MY INSURANCE

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.

Insurance Co. Name _____

Group Number (Plan, Local, Policy#) _____

Address _____

Phone _____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security# _____

Address _____ Date of Birth _____

Employer _____

LONGIE CHIROPRACTIC HEALTH CENTER

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HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for his review.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							