

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)					

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)