

Dr. David M. Heuck
Dr. Michelle L. Kerr



2222 W. Franklin St.
Evansville, IN 47712
Phone: 812-425-5686
Fax: 812-422-0429

WELCOME TO OUR OFFICE!

(Please Print)

Full Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: () _____ Cell Telephone: () _____

Social Security #: _____ Driver's License #: _____

Name of Wife, Husband or, Guardian _____

Marital Status: M S W D Age: _____ Birth Date: _____ # of Children _____

Pregnant? _____ Height: _____ Weight: _____ Occupation: _____

Employer's Name and Address: _____

Spouse's Occupation/ Employer: _____

Name of person responsible for payment: _____

Do you have insurance that covers Chiropractic care? YES NO

Name of Insurance Company: _____ Group/Policy#: _____

Address: _____ Phone: () _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

List your problems or complaints according to <u>severity of pain</u> :	Date started or for how long?	If you had the condition before, when?
---	-------------------------------	--

1. _____	_____	_____
----------	-------	-------

2. _____	_____	_____
----------	-------	-------

3. _____	_____	_____
----------	-------	-------

4. _____	_____	_____
----------	-------	-------

Is this condition interfering with your: work sleep daily routine sports/exercise

What activities aggravate your condition? _____

Other Doctors seen for this condition: Medical Dr. Chiropractor Other _____

1. Name: _____ Address: _____

When? _____ What did he say was wrong? _____

2. Name: _____ Address: _____

When? _____ What did he say was wrong? _____

List all medications you are currently taking: _____

Have you had any X-rays taken?

When? _____ Where? _____ Area of the body: _____

When? _____ Where? _____ Area of the body: _____

Do you wear orthotics or heel lifts? YES NO

(FRONT)

Accidents and or injuries: auto, work related or other (Especially those related to your present condition).

1. Type: _____ When: _____ Hospitalized? YES NO
2. Type: _____ When: _____ Hospitalized? YES NO
3. Type: _____ When: _____ Hospitalized? YES NO

NOTE: If you have **RECENTLY** been involved in an accident or injury, please inform a staff member so they may bring you an accident report form.

Have you had any surgeries?

1. Type: _____ When: _____ Doctor: _____
2. Type: _____ When: _____ Doctor: _____
3. Type: _____ When: _____ Doctor: _____
4. Type: _____ When: _____ Doctor: _____

Check the following conditions you may have had or do have now:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Malaria | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Low Blood Sugar |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Polio | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Low Back Pain |

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Westside Chiropractic Center may prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Westside Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature _____ Date: _____