Achieving Wellness Chiropractic Center
Dr. Kerri Ward
776 W. Midway Rd. Ft. Pierce., FL 34982
772-460-7999 Fax 772-460-7995

Date:_________

1 Patient Information

Name: ______________________________________

Address: ______________________________________

____

Birthday: ____/______/______/ Age: _____ Gender: ______

Social Security #:_____/_______/________

Occupation:______________________________________

Employer: ______________________________________

Parents Name (If a minor): ____________________________

☐ Single ☐ Married ☐ Divorced ☐ Separated

#of children:___Names(s):________________________

2 Insurance

Who is responsible for this account? ___________________

Relationship to patient: ______________________________

Insurance Company: _________________________________

Insurance ID Number: ______________________________

Group/Claim Number: ______________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Company: _________________________________

Subscriber # and name: _____________________________

Birthdate: _____________ Group #: ___________________

3 Accident Information

Is your condition due to an accident? ☐Yes ☐No
Date:___________________________

Type of accident? ☐ Auto ☐ Work ☐ Home ☐Other

To whom have you reported the accident?
☐ Insurance ☐ Workers Comp ☐ Employer

Attorney Name (if applicable):______________________

4 Contact Information

Home phone________________Cell:___________________

Work Phone:_________________________ext:___________

Email:____

Best way to reach you : ☐Home ☐ Cell ☐ Work ☐ Email

IN CASE OF EMERGENCY CONTACT:

Name:______________________Relationship___________

Home Phone: __________________**Cell**________________

5 Patient Condition

What is your major symptom/problem?____

When did your symptoms begin? ______________________

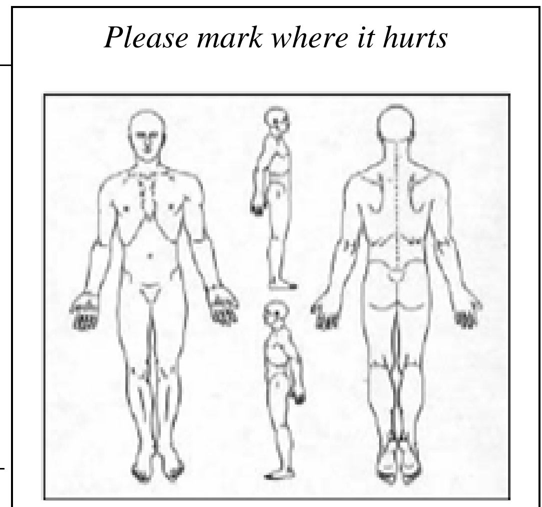
Have you had this problem before? ☐ Yes ☐ No

Is your symptom getting progressively worse? ☐ Yes ☐ No

Is this problem ☐ constant ☐ comes and goes

How does it feel? ☐ Burning ☐Tingling ☐ Sharp ☐ Shooting ☐Throbbing ☐ Dull
Circle below the severity of your pain from 0 -10:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
What makes your condition better? ____________________Worse?_______________

Please mark where it hurts



Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation?
Activities/movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Driving ☐Reading ☐ getting up
Other:____

6

Health History

What other treatments have you had for this condition?

☐ Chiropractor ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery

Name of other doctors who have treated you for this condition:
____

Previous chiropractic care? ☐ Yes ☐ No Date: ______________ ☐ Local ☐ Out of state______________

Date of last: Physical Exam:__________________ Spinal x-ray: _______________ MRI:________________

Spinal exam:___________________ Dental x-ray: _______________ CT-scan: ________________

List any medications you are taking: ____

Vitamins/Herbs/Minerals: ____

Check any of the conditions that you have had:

	Aids/HIV		Diabetes		Insomnia		Sciatica
	Allergies		Digestive problems		Irregular cycle		Shingles
	Anxiety/Depression		Earache		Kidney problems		Sinus problems
	Arm/Shoulder pain		Epilepsy		Leg pain		Stroke
	Arthritis		Headaches		Low back pain		Thyroid problems
	Asthma		Migraines		Neck pain		TMJ
	Bladder problems		Heart disease		Osteoporosis		Venereal Disease
	Cancer		Hemorrhoids		Poor circulation		Vertigo/Dizziness
	Chronic Fatigue		Herniated disk		Prostate problems		
	Deafness		High Blood Pressure		Rheumatoid arthritis		

Stressors

☐ Smoking Packs/Day: ________________

☐ Alcohol Drinks/week: ______________

☐ Coffee/Caffeine Drink Cups/Day: ________________

☐ High Stress Level Reason: __________________

Exercise

☐ None

☐ Moderate

☐ Daily

☐ Heavy

Have you had any: **Description :** **Date:**

Automobile accidents: ____

Surgeries: ____

Broken Bones: ____

Falls/Head Injuries: ____

7

Insurance Verification

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Achieving Wellness Chiropractic / Dr. Kerri Ward to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I Authorize the use of my signature an all insurance submissions.

____ ____________________ _________________________________

Signature Date Parent (if patient is a minor)