AllHealth
Chiropractic • Rehabilitation • Massage

24932 – C Aurora Road
Bedford Heights, Ohio 44146
(440) 439-9440 • Fax (440) 439-9447

27801 Euclid Ave.
Euclid, Ohio 44132
(216) 289-2632 • Fax (216) 289-2654

Patient information – please fill out all information (If Worker's Compensation) Claim #_____

Today's date: _____

Name: _____ E-mail: _____ Age: _____ Birth Date: _____

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

Phone (home): _____ Phone (cell): _____ Phone (work): _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of Children: _____

Employer: _____ Occupation: _____ How Long? _____

Employer address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Employer: _____

IN CASE OF EMERGENCY CONTACT: Name: _____

Phone (home): _____ Phone (cell): _____ Phone (work): _____ Relationship: _____

Insurance Data

Do you have health Insurance? ☐ YES ☐ NO - If yes, subscriber Health Ins. Company: _____

Patient Social Security Number: _____ Subscriber name: _____ DOB: _____

Is your problem related to a Work injury? ☐ YES ☐ NO Car or Motorcycle Accident? ☐ YES ☐ NO Wellness Care? ☐ YES ☐ NO

Date of Injury: _____ MCO: _____ Have an attorney? ☐ No ☐ Yes – Name: _____

Today's Visit

1. Symptoms you are having. _____
2. Have you had these problems before the injury? NO YES – if so, explain: _____
3. Medications currently taking: _____
4. Habits: List daily amounts: ☐ Coffee _____ ☐ Soft Drinks _____ ☐ Alcohol _____ ☐ Tobacco _____
5. Do you have cancer, diabetes, high blood pressure, heart or lung disease or other symptoms or diseases? (use other side if needed)
   _____
6. Who is your primary doctor for these pre-existing medical conditions? _____

I certify all information is true and correct. I authorize the clinic to treat me aa the clinic deems appropriate. I understand the clinic will not be held responsible for pre-existing medical conditions and will only be treating my current complaints. I understand I am ultimately responsible for bills incurred at this office and I can use my health insurance if necessary. I give the clinic permission to contact me by e-mail or phone regarding my appointments and to send my information to providers for the purpose of treatment and coordination of care.

Signature: _____ Date: _____