

# Gorman Chiropractic Life Centers

Please Print Clearly and fill In completely-front and back

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female  Right handed  Left handed  Email \_\_\_\_\_

## Health History:

Problem area(s): \_\_\_\_\_ Work related? Yes  No

Date of onset: \_\_\_\_\_ Sudden  Gradual  Duration: min  hrs  days  months  years

Pattern of problem: Constant  Intermittent  Occasional

Initiating Factors: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

List any current Medications: \_\_\_\_\_

List any past surgeries & dates: \_\_\_\_\_

List any past accidents & dates: \_\_\_\_\_

## Personal & Family History: Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse's name and health status: \_\_\_\_\_

Children's names, ages and health status: \_\_\_\_\_

## Chiropractic History:

Have you ever been to a Chiropractor before? Yes  No  If yes Doctor's Name \_\_\_\_\_

Date of last chiropractic visit \_\_\_\_\_ Reason for care \_\_\_\_\_

Date of last chiropractic x-rays \_\_\_\_\_ How long were you under care? \_\_\_\_\_

## Wellness Commitment

At Gorman Chiropractic Life Centers we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this; we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%----- 20% -----30% ----- 40% -----50% ----- 60% -----70% ----- 80% -----90% ----- 100%

Where did you hear about our office or who referred you? Friend  \_\_\_\_\_

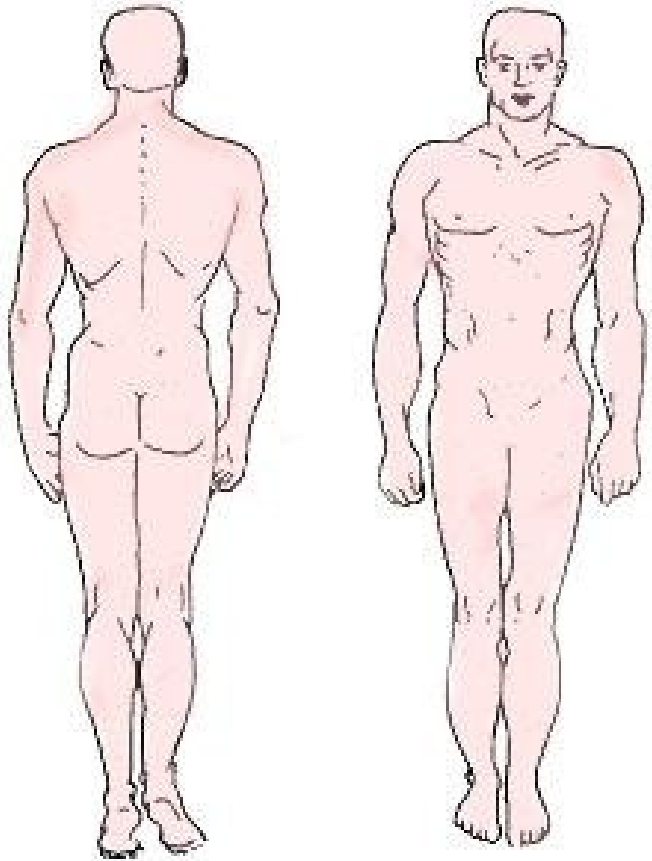
Flyer  Newspaper  Radio  Sign  Other  \_\_\_\_\_

**Please Fill in Below**

**If you have had the following, or if you suffer from the following, *Please Check* ✓**

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Grating/Grinding Neck	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>
Pins and Needles	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Faulty Posture	<input type="checkbox"/>	<input type="checkbox"/>
Painful Periods	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Cycles	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant AT This Time	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

**Circle the areas where you have any problems.  
Please also describe these problems.**



**Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.**

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*Thank you for being complete and thorough.*

## Financial Responsibility Statement

Are you going to use your insurance? Yes  No

Policy # \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

\_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Are you the primary member? Yes  No

If not, primary members name and phone #: \_\_\_\_\_

\_\_\_\_\_

Has your deductible been met for this calendar year? Yes  No  Not Sure

If you are not financially responsible for your account, who is?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### Statement to Cure

Chiropractic makes no claim to cure any condition, but only to adjust subluxations (misalignments of the spine) thus restoring better nerve supply for restoration of health.

I understand and that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Sharon Gorman and Associates will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Dr. Sharon Gorman and Associates will be credited to my account upon receipt. **If covered by insurance, I clearly understand I am responsible for my co-payments and deductible.**

**However, if I have no insurance coverage, 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, any fees for professional services rendered me will be immediately due and payable.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

