7000 Security Blvd. STE 108 Baltimore, MD 21244

## Patient Information

Date _____

***Healthcare for a Healthy Lifestyle***

Patient Name_____
Last First MI
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Best time and place to reach you_____ Email_____
Age_____ Birth Date_____ Sex: F M Marital Status: M S D
# of children_____ Spouse's Name_____ SS#:_____
Occupation_____ Name of Employer_____
Who may we thank for referring you?_____
Or Referred by: _____ Insurance Co. _____Our Website _____Phone Book _____Your Doctor
Your Doctor's Name _____Doctor's Tel. # _____
Are You Pregnant? __ Yes __ No Due Date_____

## Emergency Contact

Name_____
Relationship_____
Tel.#_____
Alternate #_____

## Accident Information

Is this condition due to an accident? __ Yes __ No
Date of Accident:_____
Type of Accident: __Auto __Work __Home
Other_____
To Whom Have You Reported Your Accident?
__Auto Ins. __Employer __Workers Comp. __Attorney
Attorney's Name_____
Attorney's Tel. #_____

## Present Condition

Reason for your visit_____
How long have you been suffering ?_____
Is this condition getting progressively worse ? _____ Yes _____ No _____ Unknown
Do you know what caused it ?_____
Rate the severity of your pain on a scale of 1 (least pain) to 10 ( most pain) _____
Please check all that apply to describe your pain:
__ Sharp __ Dull __ Throbbing __ Numbness __ Shooting __ Squeezing
__ Burning __ Tingling __ Stiff __ Aching __ Cramps __ Other_____
How often do you suffer from the above ?_____
Is it constant or does it come and go ?_____
How is it effecting your quality of life ? Please check all that apply:
__Work __School __Sleep __Walking __Sitting __Standing
__Bending __Lying down __Eating __Mood __Energy __Relationships
__Exercise __Daily Routine __Recreation, be specific_____
What have you already tried in order to resolve this problem?
__ Medication __ Surgery __Physical Therapy __ Massage __ Chiropractic
__ Acupuncture __ Nothing __ Other_____

## Health History

Please place a check next to all those that you have or have had in the past:

_ Aids/HIV
_ Alcoholism
_ Allergies
_ Anemia
_ Anxiety / Depression
_ Appendicitis
_ Arthritis
_ Asthma
_ Bleeding Disorders
_ Breast Lumps
_ Bronchitis
_ Constipation/Diarrhea
_ Cancer
_ Cataracts
_ Chemical Dependency
_ Chicken Pox
_ Diabetes
_ Dizziness
_ Emphysema
_ Epilepsy
_ Fatigue
_ Fractures
_ Glaucoma
_ Gout
_ Heart Disease
_ Hepatitis
_ Hernia
_ Herniated Disc
_ Herpes
_ High Cholesterol
_ Kidney Infection / Stone
_ Liver Disease
_ Measles
_ Migraines / Headaches
_ Miscarriage
_ Mononucleosis
_ Multiple Sclerosis
_ Mumps
_ Osteoporosis
_ Pacemaker
_ Parkinson's
_ Pinched Nerve
_ Pneumonia
_ Polio
_ Prostate Problems
_ Prosthesis
_ Psychiatric Care
_ Rheumatoid Arthritis
_ Rheumatic Fever
_ Reflux
_ Scarlet Fever
_ Stroke
_ Suicide Attempt
_ Sleep Problems
_ Thyroid Problems
_ Tonsillitis
_ Tuberculosis
_ Tumors
_ Ulcers
_ Vaginal Infections
_ Whooping Cough

Please list any surgeries or accidents that you have had and when_____

_____

_____

## Medications

1._____
2._____
3._____
4._____
5._____

## Wellness Objectives

At the Silver Wellness Center, we are dedicated to helping you achieve all your health goals. Therefore, in order to serve you better please check all that apply that meet your health objectives:

__ Maximum Correction
__ Wellness & Prevention
__ Symptom / Temporary Relief
__ Restore Health
__ Improved Performance

## Habits

| | Light | Mod. | Heavy |
|---|---|---|---|
| Alcohol | __ | __ | __ |
| Coffee | __ | __ | __ |
| Smoking | __ | __ | __ |
| Drugs | __ | __ | __ |
| Exercise | __ | __ | __ |
| Sleep | __ | __ | __ |
| Appetite | __ | __ | __ |
| Soda | __ | __ | __ |
| Water | __ | __ | __ |

## Communication Channels

To help us better explain your Chiropractic condition and how we may be able to help you, please check the best answer:

1. **I remember important things in my life by**
   __What I see __What I hear __ What I feel
2. **The primary reason I brush my teeth is to**
   __Avoid tooth decay and gum disease
   __make sure I have healthy teeth and gums
3. **When I make decisions I generally**
   __Gather facts and weigh the evidence
   __Make the right choice instantly
   __Consult my family and friends
   __ Depend on how "I feel" about it

## Insurance Information

Do you have health insurance ? __ Yes __ No If no please skip to Authorization

**Primary Ins.**
Carrier_____
Policy #_____
Group#_____
Policy Holder_____
Date of Birth_____
Social Security #_____
Relationship to Patient_____

**Secondary Ins.**
Carrier_____
Policy #_____
Group#_____
Policy Holder_____
Date of Birth_____
Social Security #_____
Relationship to Patient_____

## Insurance Agreement

I understand and agree that health and accident insurance policies are a contract between an insurance carrier and a policy holder and that I am ultimately responsible for any services and/or treatment I receive at this office. Furthermore, I authorize this office to release any medical information and to complete any reports and forms to assist in collecting from my insurance carrier. I understand that any payments for services/treatments at this office will be credited to my account upon receipt of payments for said services/treatments. However, I clearly understand and agree that all services/treatments rendered to me are charged directly to me and that I am personally responsible for payments. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will immediately become due and payable.

I understand the insurance verification done by this office and quoted to me as provided by my insurance representative is not a promise or guarantee of payment by my insurance carrier and I will not hold this office responsible for discrepancies in the benefits quoted and the benefits actually paid.

Patient's Signature_____ Date_____
Parent's Signature (for a minor)_____ Date_____

## Authorization

I herby authorize Dr. Warren Silver to examine me, and after reviewing my findings with me, to treat my condition as he deems appropriate through the use of the various different techniques and modalities that fall under Chiropractic Health Care. I understand that I have the right to question Dr. Silver on the risks associated with any/all procedures being performed. Once my questions are answered I give authority for these procedures to be performed, assuming all risks. I also understand that at any time I have the right to deny any of the services.

I also affirm that the information I have provided on this health information form is true and accurate to the best of my knowledge. I also agree to report any changes to my health, name, address or other pertinent information to this office immediately of said changes.

Patient's Signature_____ Date_____
Parent's Signature (for a minor)_____ Date_____