

83 East Avenue
Suite 313
Norwalk, Conn. 06851
(203)838-9795

Welcome

Dr French and his staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Insurance

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Patient Identification

Name _____ Name you would prefer to be called in this
office _____
Address _____ Telephone
(Home) _____
Date of Birth _____ (Office) _____
SS# _____ Occupation _____

Emergency Contact Name _____
Telephone _____
Parent's Name
(if minor) _____

Whom may we thank for referring you? _____

Email Address _____

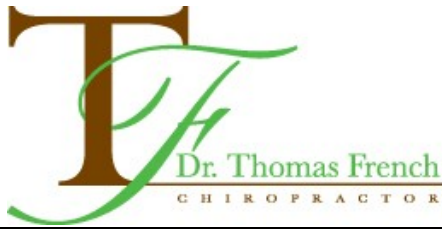
Primary Care Physician _____ Location _____

Acceptance as Patient

I understand that Dr French has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Date _____

Signature _____



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Patient Name _____

Do you have Dizziness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drooping eyelid or change in your pupils?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you pass out easily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have double vision or loss of sight in one eye?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had a stroke?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Slurred speech or difficulty with speech?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does your pain wake you up?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Indigestion or difficulty swallowing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you losing weight without trying?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty walking, coordination or falling to one side?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nausea or vomiting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you had a recent fever of over 102°?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Numbness on one side of your face or body?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have a congenital bone or joint disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Visual disturbances?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had a compression fracture?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a headache unlike any headache you've had before?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had gout?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Pain?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you take birth control pills?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Change in bowel or bladder habits?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood pressure medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nagging cough or hoarseness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood thinners?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Night sweats?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you taken steroids or intravenous drugs for more than 3 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please list any medications you are taking _____

Please list any vitamins or supplements you are taking _____

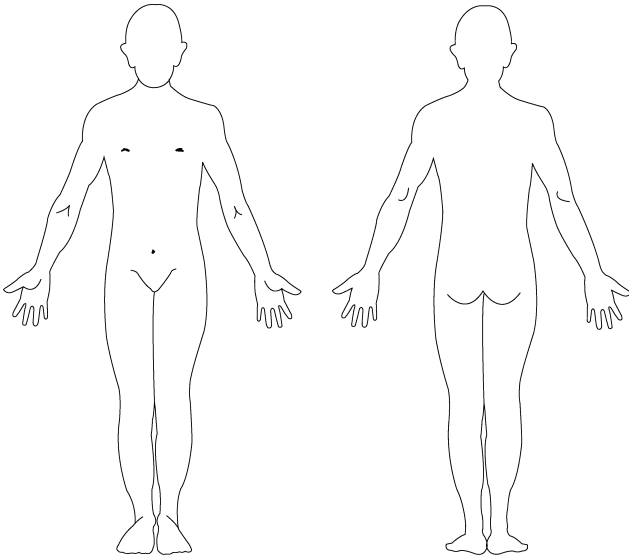
Please list any ongoing health issues (Lyme's disease, diabetes, fibromyalgia, etc.) _____

Family History

Please indicate whether you have any of these in your family:

- | | |
|-------------------------|---------------------|
| () High Blood Pressure | () Arthritis |
| () Heart Attack | () Thyroid Disease |
| () Emphysema | () Cancer |
| () Seizure | () Stroke |

Please indicate the location of your symptoms by marking the picture.



Describe your symptoms briefly _____

Rate the intensity of your symptoms from 1 to 10 _____

When did your symptoms begin? _____

How did they begin? _____

Do not write below this line

Treatment Plan	Goals