37 Spanish Peak Drive
Bozeman, MT 59718
(406) 261-7808
info@hunterfamilychiropractic.com

Name	First	Last	Date of Birth	____/____/____	Date	
Mailing Address	Street		City		State	Zip
Contact Information	Home Phone ( ) -	Cell Phone ( ) -	Email Address			

Who can we thank for referring you to our office?______________________________

What brings you in today?______________________________

____

When did you first notice this issue?______________________________

What activities does this prevent you from doing?______________________________

Have you sought care for this issue with any other professional?______________________________

What benefits are you expecting to see from chiropractic care?

____

Have you had any surgeries to your spine ? Y / N
(if yes please describe the operation, location and date)______________________________

Do you currently have X-Rays of your spine? Y / N
(if yes please state the provider to get in touch with for these records)______________________________

Are you on any medications that alter bone density? Y / N
(if yes please state the name/dosage/duration)______________________________

Have you ever been diagnosed with any form of arthritis or have a family history or arthritis ? Y/ N
(if yes describe condition, where and when you were diagnosed)______________________________

Do you have a history or a family history of any auto-immune diseases? Y / N

(if yes please describe)______________________________

Have you ever been diagnosed with osteoporosis or osteopenia? Y / N
(if yes describe condition, where and when you were diagnosed)______________________________

Have you ever had prolonged use of corticosteroids? Y / N
(if yes describe the purpose and the duration)______________________________

Have you ever had any significant trauma to your head, spine or pelvis such as a fall or car wreck? Y/ N
(if yes describe the event in detail)
____

____

Were you born under extraordinary circumstances (C-Section, Forceps, Vacuum Delivery) Y / N

(if yes please describe)______________________________

Insurance and Payment Info

I authorize my insurance company to pay to this office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the release of all information necessary to secure the payment of benefits, within accordance of our compliance policy.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient or Guardian Signature____Date:_________________

Payment is due in full at the time of service unless prior arrangements have been made