



8924 E 96th Street
Fishers, IN 46037
(317) 863-8424

WELCOME TO INFINITY HEALTH – WE'RE GLAD YOU ARE HERE

Name: _____ Age: _____ Today's Date: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone (home): _____ (cell) _____ Preferred Contact: Home / Cell / Either
SSN#: _____ No. of Children: _____ Birth date: ____/____/____
E-Mail: _____ I Am: Married Single Divorced Partnered Widow
Occupation/Employer/School: _____
Emergency Contact/Relationship: _____ Phone: _____
How did you hear about us? Location Doctor Internet Ins Co Referral Friend or Family Member
Who can we thank for referring you? _____

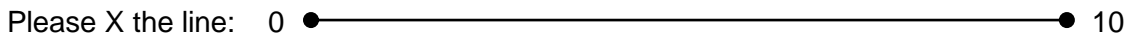
We promise to treat you with respect, compassion, and understanding.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Reason for today's visit? _____

If you have no symptoms or complaints, and are here for wellness services, please check (√) here and skip to **"Your Health History"** Or, describe your **chief area of complaint**, including the effect it has on your life:

On a scale of 0 – 10, please rate your pain (with 10 being unbearable and 0 being no pain):



If you are experiencing pain, is it: Sharp Dull Comes and goes Travels Constant
Since the condition or concern started, it is: About the same Getting better Getting worse
What makes it worse: _____
Does it interfere with: Work Sleep Walking Sitting Hobbies Leisure
Other Doctors seen for this condition (please list):
 Chiropractor _____
 Medical Doctor _____
 Other / Alternative Care _____

List any medications/supplements you are currently taking: _____

Describe your current stress level (0 = none / 10 = extreme): Work: _____ Home: _____
Rate each Area on a scale of Poor – Good – Excellent
Diet: Poor Good Excellent Sleep: Poor Good Excellent
Exercise: Poor Good Excellent General Health: Poor Good Excellent

UNDERSTANDING YOUR HEALTH HISTORY

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current condition.

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Neurological | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Psoriasis/Eczema |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Accident - Major |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Thyroid | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Stomach Ulcer |

Family Health Profile:

At Infinity Health we are not only interested in your health, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
 Spouse _____
 Mother _____
 Father _____
 Brothers _____
 Sisters _____
 Others _____

YOUR HEALTH PROFILE

Why this section is important: At Infinity Health, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Please answer the following questions the best you can:

YOUR CHILDHOOD YEARS:

Did you have any childhood injuries?	Yes	No	Unsure	Did you suffer any other traumas (physical or emotional)?	Yes	No	Unsure
Did you have any serious falls as a child?	Yes	No	Unsure	Were you vaccinated?	Yes	No	Unsure
Did you play youth sports?	Yes	No	Unsure	As a child, were you under regular Chiropractic care?	Yes	No	Unsure
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)	Yes	No	Unsure	Did you have any surgery?	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No	Unsure	Were involved in any other accidents as a child?	Yes	No	Unsure
Did you take /use any drugs?	Yes	No	Unsure	Did you have a difficult or traumatic birth?	Yes	No	Unsure

You're almost done, just one more page!

YOUR HEALTH PROFILE - CONTINUED

Please tell us about your health as an adult (18 to Present):

YOUR ADULT YEARS:

	YES	IN THE PAST	NO		YES	IN THE PAST	NO
Do/did you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you play adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you consume soda on a daily basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take daily medications? (legal or not)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAYMENT INFORMATION

How will payment be made? Self / Cash Health Insurance Auto/Injury Insurance Work Accident
 Medicare Medicaid/BadgerCare Other: _____

Carrier Name: _____

Primary Insured: (if not you): _____ DOB: _____

Insurance SSN or Group # _____

Date of Injury (If applicable): _____ Claim # _____

Auto Ins Name: _____ Attorney Name: _____

INSURANCE ASSIGNMENT & RELEASE OF RECORDS

I certify that I, and /or my dependent(s), have insurance coverage with the above Carrier and assign directly to Infinity Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Infinity Chiropractic may use my health care information and may disclose such information to my insurance Carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I hereby authorize the doctors at Infinity Chiropractic to perform an examination, including x-rays if indicated, and to provide chiropractic services to me (or my dependants) based on the information provided herein.

Signature of Patient, Parent, Guardian or Personal Representative

Please **Print Name** of Patient, Parent, Guardian or Personal Representative

YES NO
 YES NO

I would like to discuss payment options in order to afford care that I may need.
I am interested in long-term wellness for my family.

Welcome to our office!



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