



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)	_____
	_____	(Office)	_____
Date of Birth	_____	Occupation	_____
	Male <input type="checkbox"/> Female <input type="checkbox"/>		
Emergency Contact	Name	_____	
	Telephone	_____	
Parent's Name (if minor)	_____		
Who may we thank for referring you?	_____		

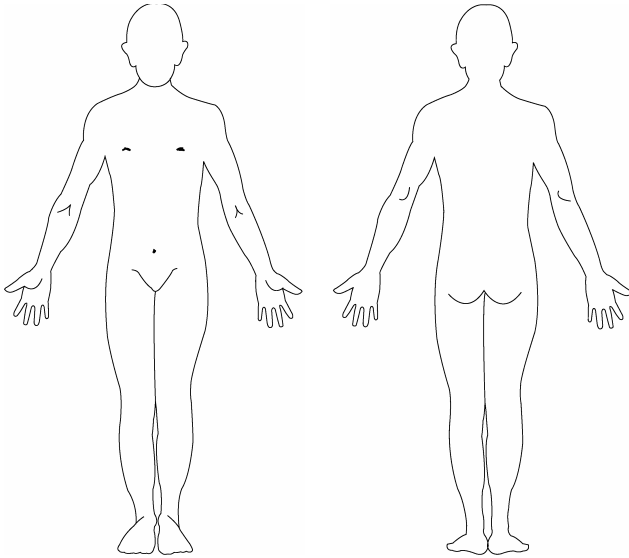
### Acceptance as Patient

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 \_\_\_\_\_

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? \_\_\_\_\_

Have your symptoms been improving? \_\_\_\_\_

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Do not write below this line

Treatment Plan	Goals



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Patient Name \_\_\_\_\_

Do you have Dizziness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Draping 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          |



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**Patient Information for Insurance**

Name \_\_\_\_\_ Marital Status S M D W  
 Street \_\_\_\_\_ Gender M F  
 City, State, Zip \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Phone \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

**Insurance Information**

(You may omit this section if we have your card)

Insurance Co \_\_\_\_\_  
 Policy # \_\_\_\_\_  
 Group# \_\_\_\_\_

**Patient Employment**

Employer \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_

**Primary Insured** (if other than patient)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Employer \_\_\_\_\_

**Secondary Insurance** (if applicable)

Insurance Co \_\_\_\_\_  
 Policy # \_\_\_\_\_  
 Group# \_\_\_\_\_

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

For office use	
Insurance Phone # _____	Out of Network Benefits? _____
Claim Address _____	Chiropractic Visits per year _____
_____	X-Rays Covered _____
_____	Treatment Plan Required? _____
_____	Referral required? _____
Coverage Effective Date _____	Massage covered? _____
Deductible _____	
Amt Met This Year _____	
Co-Pay _____	