



Confidential Patient Information

Coulee Health
920 W Cty Hwy 16 Suite A
West Salem, WI 54669

(608) 612-0777 Phone
(608) 807-5142 Fax
www.couleehealth.com

Date: ____/____/____

Patient's Full Name _____

Parent/Guardian (s) Full Name(s) _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____ E-Mail: _____

Male Female Date of Birth: ____/____/____

Number of Siblings/Ages _____

How did you find us?

- | | | |
|--|---|---|
| <input type="checkbox"/> Existing Patient
Name: _____ | <input type="checkbox"/> Office Website | <input type="checkbox"/> LaCrosse Chamber |
| <input type="checkbox"/> Physician
Name: _____ | <input type="checkbox"/> MPI Website | <input type="checkbox"/> Google: _____ |
| <input type="checkbox"/> Friend
Name: _____ | <input type="checkbox"/> Other Website: _____ | <input type="checkbox"/> Social Media (i.e. Facebook) |
| <input type="checkbox"/> Other _____ | | |

Social Security # _____ - _____ - _____

Emergency Contact: _____ Relationship: _____ Phone: _____ - _____ - _____

Family Physician: _____ City: _____ State: _____ Phone _____

Previous Chiropractic Care: Yes No If Yes, for what Problem: _____

Doctor's Name _____ City: _____ State: _____

Is Today's Visit Due To An Auto Accident: Yes No

(If yes, please check with receptionist, additional information is needed)

Date of Injury: _____

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Coulee Health, Spine and Bodyworks, LLC) are **paid in full.**

Parent/Guardian Signature: _____ Date: ____/____/____

Dear Parent/Guardian: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe this child will respond satisfactorily, we will not accept your case. THANK YOU.



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Health History:

Full Term Preterm If so, # of weeks _____ Post-term

Type of Delivery: Vaginal C-section If so, please explain in space provided below.

Check movement milestones that child achieved Rolling Crawling Sitting Walking

Did the child achieve milestones in the above order? Yes No

If no, please explain

What is your primary reason for seeking chiropractic care for the child/adolescent?

Are there any recurring illnesses that this child/adolescent experiences?

Has the child/adolescent ever been in an automobile accident or significant injury? Please explain

In the space below please explain in further detail any of the above information, as needed: _____
