Patient Information

Name (full name please) _____ Date: ____/_____/_____

Address _____ City _____ State _____ Zip _____

Email: _____

Age _____Date of Birth _____ SS# _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

Marital Status: S M D W Sep Name of Spouse/Partner _____ Ages of Children _____

Have you had chiropractic care before? ☐Yes ☐No DC's Name_____

How long has it been since your last Chiropractic adjustment? _____

How did you hear about us? ☐ Location ☐ Doctor ☐ Social Media ☐ Website ☐ Insurance Company ☐ Friend/Family

Who can we thank for referring you? _____

My complaint is due to: ☐ Auto Accident ☐ Work Accident ☐ Sports Accident ☐ Home Accident ☐Other:_____

History of Concern

I am seeking help for (Please circle all that apply):

Sinus	Neck Pain	Upper Back Pain	Middle Back Pain	Low Back Pain
Migraines	Neck Stiffness	Shoulder Pain	Asthma	Hip Pain
Headaches	Numbness	Arm Pain	Chest Pain	Leg Pain
Jaw Pain/TMJ	Weak Immunity	Elbow Pain	Ulcers	Knee Pain
Allergies	Depression	Hand/Wrist Pain	Nervousness/Tension	Ankle/Foot Pain
Fibromyalgia	Chronic Infection	Menstrual Problems	Arthritis	Sciatica
General Health	Sports Performance	Infertility	Chronic Fatigue	Digestion

Primary Complaint (list only one) _____ Date Complaint Began_____

What do you believe caused this concern? _____

How did symptoms start? ☐Sudden ☐Gradual Are symptoms? ☐ Constant ☐ Intermittent ☐ Occasional

What is the intensity of the pain? (0= No Pain, 10=Worst Pain Possible) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What makes it worse? ☐Change Positions ☐Bend ☐Lift ☐Twist ☐Walk ☐Sit ☐Lay ☐Cough/Sneeze ☐Other_____

_____

What makes it better? ☐Sit ☐Lay ☐Movement/Exercise ☐Medications ☐Ice ☐Heat ☐Nothing ☐Other_____

_____

Has this interfered with your daily activities? ☐Not Affecting Activities ☐Job ☐Recreation ☐Social Life ☐Sleep ☐Appetite ☐Energy Level ☐Immunity ☐ Other_____

Have you suffered with this or a similar problem in the past? ☐ No ☐ Yes Date of last episode? _____

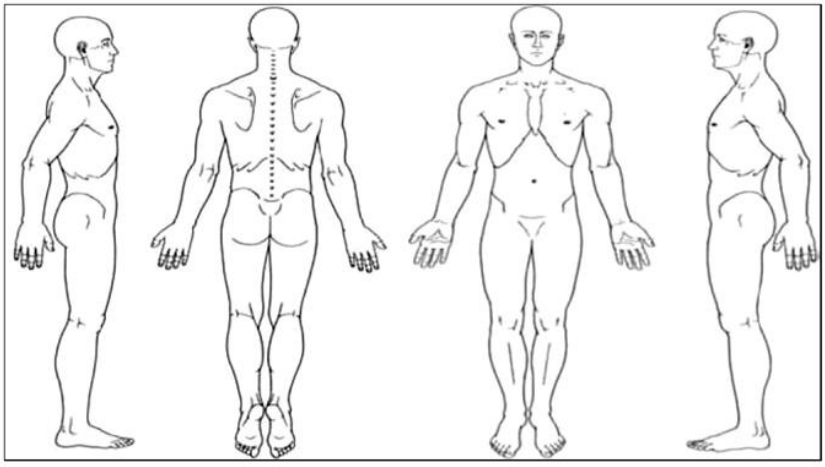
Other forms of treatment tried: ☐ Medications ☐Physical Therapy ☐Massage ☐Acupuncture ☐Other:_____

How long ago? _____What were the results? ☐Favorable ☐Unfavorable

I desire: ☐Maximum Improvement ☐Temporary Relief

***PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms:

R = Radiating
B = Burning
D = Dull
A = Aching
N = Numbness
S = Sharp/ Stabbing
T= Tingling



Health History

When was your last medical physical (Name of Doctor and Approximate date)? _____

Have you had any illnesses/injuries that required hospitalization or surgery? **Please List**_____

_____

Have you had any surgery to the spine? **Please List Date & Procedure**_____

_____

Do you have any chronic illnesses? **Please List** _____

_____

Have you had any sports/auto accident related injuries/trauma? **Please List Date & Injury**_____

_____

Are you taking any prescription or medications OTC medications, vitamins, supplements? **Please List**_____

_____

_____

Lifestyle and Habits – Please list daily amounts for each of the areas that apply to you.

Coffee/Caffeine □No □Yes_____ Sweetened Beverages □No □Yes_____ Water □No □Yes_____

Alcohol □No □Yes_____ Tobacco □No □Yes_____ Recreational Drugs □No □Yes_____ Exercise □No □Yes_____

Sleep (# hours per night) _____ Stress (Rate from 0-10, 0=No Stress, 10=Max Stress) _____

How would you rate your overall health? _____ Poor ____Fair ____Good ____Excellent

Females Only: Are you pregnant at this time? ____No ___Yes, Expected Due Date:_____

Review of Systems

Please mark P for in the Past, C for Currently (Leave Blank for Never)

___Osteoporosis	___Arthritis	___Scoliosis	___Neck Pain
___Back Problems	___Hip Disorders	___Knee Injuries	___Foot/ankle Pain
___Shoulder Problems	___Elbow/wrist Pain	___TMJ Issues	___Poor Posture
___Anxiety	___Depression	___Headache	___Dizziness
___Pins & Needles	___Numbness	___High Cholesterol	___Angina
___High Blood Pressure	___Low Blood Pressure	___Poor Circulation	___Shortness of Breath
___Excessive Bruising	___Asthma	___Apnea	___Emphysema
___Hay Fever	___Shortness of Breath	___Pneumonia	___Eating Disorder
___Ulcer	___Food Sensitives	___Heartburn	___Constipation
___Diarrhea	___Blurred Vision	___Ringing in Ears	___Hearing Loss
___Chronic Ear Infection	___Loss of Smell	___Loss of Taste	___Skin Cancer
___Psoriasis	___Eczema	___Acne	___Hair Loss
___Rash	___Thyroid Issues	___Immune Disorders	___Hypoglycemia
___Frequent Infection	___Swollen Glands	___Low Energy	___Kidney Stones
___Infertility	___Bedwetting	___Prostate Issues	___Erectile Dysfunction
___PMS Symptoms	___Menstrual Problems	___Fainting	___Poor Appetite
___Fatigue	___Low Libido	___ Weakness	___Sudden weight gain/loss

Name_____ Date: _____/_____/_____

FAMILY HEALTH HISTORY

Please review the listed diseases and conditions and indicate those that are **current** health problems of a family member by the designation **C** under his/her column. The designation **P** should be used to indicate a **past** problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	FATHER	MOTHER	SPOUSE	SIBLING	SIBLING	SIBLING	CHILD	CHILD	CHILD
	Age:	Age:	Age:	Age:	Age:	Age:	Age:	Age:	Age:
CONDITION									
Arthritis									
Asthma/Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problems									
Emotional Problems									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Syphilis									
Other									

If any of the above family members are deceased, please list their age at death and cause:_____

_____

_____

Patients Signature _____

Name _____ Date: _____/_____/_____

Payment and Insurance Information

Payment is expected at the time of each visit.

I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am responsible for any and all services covered and non-covered. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize the doctor and his/her staff to release and information deemed appropriate concerning my medical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release him her of any consequence there of. I agree that a photocopy of the dimensional serve as the original.

I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that for a copy of this agreement shall serve as the original.

I understand that payment is expected at the time of service. I choose to pay by:

___ Cash/Check ___Credit Card ___Group Health Insurance

___Worker's Compensation ___Auto Insurance ___Medicare

___Medicaid ___Other:_____

Patient Signature: _____ Date: _____/_____/_____

(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

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

Please fill in information as <u>completely</u> as possible so insurance claims are <u>accurate</u>.

Name of policy holder _____ Relationship to patient _____

Policy holder's address (if different from patient's)_____

Phone# _____ Date of birth _____ SS# _____

Policy holder's employer (and address) _____

_____

Insurance Company _____ Insured's ID number _____

Insurance Company's address _____

_____

Insurance Company's Phone # _____ Fax# _____