PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. **(Please Print)**

Name _____ S/S _____-____-_____ Date_____
Address _____City_____State_____ Zip _____
Sex (circle) Female Male Date of Birth _____/_____/_____
Home phone # (_____) _____Cell # (_____) _____ Email address: _____
I am: (circle one) a minor Married Divorced Widowed Single Separated
Your Employer _____Occupation_____
Business Add_____ City _____State _____Zip _____
Spouse or Parent's name _____Employer _____Phone _____
Person to contact in case of emergency_____ Phone # (_____) _____
Who referred you? _____

INSURANCE INFORMATION

Primary *(present card to receptionist)*
Insurance _____ Primary Insured Name _____
Policy #/ SS# _____Date of Birth _____/_____/_____
Secondary *(present card to receptionist)*
Insurance _____ Primary Insured Name _____
Policy #/ SS# _____Date of Birth _____/_____/_____

CHIROPRACTIC TREATMENT CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interests, based upon the facts as they are then known.

X_____ _____/_____/_____

Signature of Patient (or parent if a minor) Date

AUTHORIZATION/FINANCIAL RESPONSIBILITY

I authorize the chiropractor to release any information concerning my diagnosis and medical records about any treatment or examination rendered to me or my child during the period of chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the chiropractor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that payment for services and/or the applicable copayment is due at the time of service.

X_____ _____/_____/_____

Signature of Patient (or parent if a minor) Date

CURRENT CONDITION

What are your objectives in visiting the chiropractor?

_____
_____
_____

If you are here due to pain, please describe what you were doing when the pain first occurred.

_____
_____

Describe what your pain feels like.

_____

What do you do to relieve the pain? _____

Please list any major accidents, falls or injuries within the approximate date.

_____

_____

_____

How do the following activities change your pain and what duration of time can you tolerate each activity?

No Change Relieves Increased Duration

Sitting [ ] [ ] [ ] _____

Looking up [ ] [ ] [ ] _____

Walking [ ] [ ] [ ] _____

Looking Down [ ] [ ] [ ] _____

Standing [ ] [ ] [ ] _____

Turning [ ] [ ] [ ] _____

Lying Down [ ] [ ] [ ] _____

Bending [ ] [ ] [ ] _____

Lifting [ ] [ ] [ ] _____

On a scale of 1-10, rate the severity of your pain. If your pain fluctuates please mark both and indicate approximately the % of time at each level Example 0 1 2 3 4 5 6 7 8 9 10

70% 30%

No Pain Severe Pain

Neck Pain 0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain 0 1 2 3 4 5 6 7 8 9 10

Low Back Pain 0 1 2 3 4 5 6 7 8 9 10

Other 0 1 2 3 4 5 6 7 8 9 10

If you have ever visited a chiropractor or chiropractors in the past, please list:

_____

What did you like or not like about your previous treatment experiences?

_____

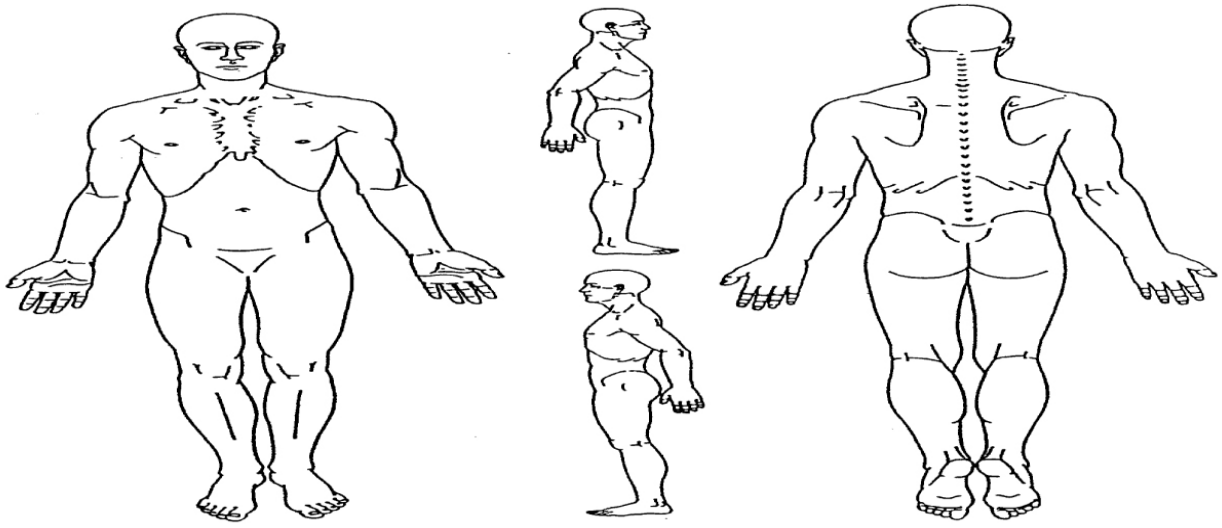
Mark the areas on this body where you feel pain. Use the appropriate symbols.

KEY:

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE B = BURNING C = STABBING

N = NUMBING P = PINS & NEEDLES O = OTHER



Please give approximate date of last:
Spinal Exam _____ Physical Exam_____
Spinal X-Ray _____ Other Spinal Imaging _____

MEDICAL CONDITIONS/MEDICATION (use Y or N for Yes/No answers)

Please list any medical conditions you are being treated for currently and what action is being taken: _____
_____
_____
List the main conditions for which you have been treated in the last 10 years.
_____
Have you ever been hospitalized? _____ If yes, please list hospitalizations/surgeries:
_____
_____
Have you ever had a fractured bone? _____ If so which bones? _____
Do you take medications? If so, please list: _____
Are you allergic to any medications? _____
Do you take vitamins, herbs or other supplements? _____ If so, please list: _____
_____
_____
Are you interested in knowing what vitamins/supplements may benefit you? _____
Who is your Primary Care Physician? _____

GENERAL HEALTH QUESTIONS

Do you currently smoke? _____ Have you smoked longer than 6 months in the past? _____
If yes, how long ago did you smoke? _____ When did you quit smoking? _____
Do you exercise? _____ If so, how many times per week? _____
Do you eat a balanced diet? _____ Do you eat many junk foods? _____
Do you drink pop? _____ If so, how many cans per day? _____
Do you drink coffee? _____ If so, how many cups per day? Do you drink alcohol? _____
If so, about how many drinks per week?_____ Do you floss your teeth?_____
About how often?_____ Are you concerned about your weight?_____
Are you interested in visiting with the chiropractor about achieving certain health goals? _____
If so, which health goals are you most interested in? _____
_____
Have you ever been depressed for long periods of time? _____ Are you frequently tired or out of energy? _____ Is your sleep pattern irregular or restless?_____ Are you ever tired to the point of nervous exhaustion? _____ Do you have any current emotional problems? _____ If so, please explain: _____
_____
Have any of the following occurred recently? (circle) increased work stress, family problems, death, divorce, change of job, chronic fatigue, anxiety, economic stress, other _____

Please UNDERLINE all of the following conditions you have had PREVIOUSLY.
CIRCLE all of the following conditions you have NOW.

GENERAL

Headache
Fainting
Diabetes
Cancer
Fainting
Epilepsy
Dizziness
Convulsions
Weight loss
Weight gain
Allergy

E.E.N.T.

Failing vision
Near sighted
Far sighted
Crossed eyes
Deafness
Earache

RESPIRATORY

Chronic cough
Pneumonia
Pleurisy
Asthma

SKIN

Skin eruptions
Varicose veins
Sensitive skin
Hives
Eczema

CARDIO-VASCULAR

Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Previous heart stroke
Hardening of arteries
Swelling of ankles

MUSCLE/JOINT

Head injury
Spinal injury
Tail bone injury
Shoulder / elbow
Wrist / hand

Hip / knee
Ankle / foot
Spinal / curvature
Faulty posture
Arthritis
Polio
Gout
Swollen joints
Hernia
Chronic fatigue
Fibromyalgia

GENITOURINARY

Frequent urination
Painful urination
Kidney infection/stone
Bed wetting
Inability to control urine
Prostate trouble

GASTROINTESTINAL

Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Stomach pain
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis
Irritable bowel

FOR WOMEN ONLY

Painful menstrual periods
Excessive flow
Hot flashes
Cramps or backache
Previous miscarriage
Lumps in breast
Menopausal symptoms
Are you pregnant?
Yes ____ No _____