WELCOME!

Today's Date_______________

Name_________________________________ Date of Birth__________________ Phone ______________________

What do you prefer to be called?______________________ Age_______________ SS#___________________________

Address _____________________________________City______________________ State____ Zip____________

Occupation___________________________________Employer Name______________________________________

Work Phone #_________________ Employer's Address ____

Would you like to receive our free newsletter via e-mail? E-mail address ______________________________________

Marital Status: ❑Single ❑Divorced ❑Married Spouse's Name____

# of children and ages____________________________________

Who may we thank for referring you to our office? ____

Have you ever been treated by a Chiropractor before? ❑Yes ❑No If so Whom?_____________________________

For what condition: ____

INSURANCE INFORMATION

Insured's Name __________________________________ Relation_______________ Date of Birth ______________

Insured's SS#____________________ Insured's Employer ____

Your Ins. Co. ____Group # ___________

Ins Co. Address ____

Ins Co. Phone #____

Person Ultimately Responsible for Account (Name and Address if different from above) __________________________

____

REASON FOR VISIT

The reason for this visit is a result of: ❑Work ❑Sports ❑Auto ❑Trauma ❑Chronic

When did the condition begin? ___/___/___ The onset was: ❑Gradual ❑Sudden

What is your current primary problem? ____

Other problems? ____

____

Drs.Notes ____

____

____

What will cause your pain to **WORSEN**? ____

What gives you the **GREATEST RELIEF / CONTROL** of pain? ____

How long can you sit _______________, stand ________________, drive ______________, walk ________________

Do you have difficulty with? ❑Dressing ❑Personal Hygiene ❑House / yard work ❑Preparing meals

Are there any other activities of daily living that you are having difficulty with due to your presenting complaint(s)? _______

____

Please describe the pain and its location:____

____

____

Is this condition getting worse? ❑Yes ❑No ❑Constant ❑Comes and Goes

Is there radiation or referral of pain to other areas? ❑Yes ❑No Where? ____________________

On a scale of 0-10 please rate your pain (0=no pain, 10=extreme pain) _______

Dr.'s. notes: ____________________

____

HISTORY

Previous Injuries: ❑Auto ❑Work Comp ❑Other: ____________________ Date(s): ____________

Same or similar symptoms: ❑Yes ❑No Previous Symptoms: ____________________

____

Previous treatment & diagnostic tests:

1. Dr. ______________ Date of 1st office visit ______________ X-Rays __________

   Treatment: ____________________ % Improvement ________

2. Dr. ______________ Date of 1st office visit ______________ X-Rays __________

   Treatment: ____________________ % Improvement ________

❑MRI ______________ ❑CT ______________ ❑EMG ______________

❑Bone Density Scan ______________

SYSTEM REVIEW / PAST MEDICAL HISTORY

	Current	Past		Current	Past		Current	Past
Fever	❑	❑	Heart Attack	❑	❑	Venereal disease	❑	❑
Chills	❑	❑	Stroke	❑	❑	Seizures	❑	❑
Night Sweats	❑	❑	High Cholesterol	❑	❑	Fainting	❑	❑
Weakness / fatigue	❑	❑	High Triglycerides	❑	❑	Memory problems	❑	❑
Recent weight change ↑ ↓	❑	❑	High/Low Blood Pressure	❑	❑	Pallor/cyanosis	❑	❑
Growing moles	❑	❑	Heart Murmur	❑	❑	Sweating	❑	❑
Ringing in Ears	❑	❑	Congenital Heart Defect	❑	❑	Reaction to hot / cold	❑	❑
Hearing Loss	❑	❑	Mitral Valve Prolapse	❑	❑	Vertigo (whirling)	❑	❑
Light bothers eyes	❑	❑	Artificial Valve	❑	❑	Dizziness	❑	❑
Blurred vision	❑	❑	Rheumatic Fever	❑	❑	Poor balance	❑	❑
Glaucoma	❑	❑	Heart Surgery/Pacemaker	❑	❑	Epilepsy	❑	❑
Hoarseness	❑	❑	Asthma	❑	❑	Shingles	❑	❑
Swallowing difficulty	❑	❑	Cough	❑	❑	Motion sickness	❑	❑
Allergies	❑	❑	Emphysema	❑	❑	Hypothyroid	❑	❑
Sinus Problems	❑	❑	Tuberculosis	❑	❑	Hyperthyroid	❑	❑
Loss of Smell	❑	❑	Difficulty breathing	❑	❑	Diabetes	❑	❑
Speech difficulty	❑	❑	Heartburn	❑	❑	Excessive thirst / hunger	❑	❑
Joint swelling	❑	❑	Hernia	❑	❑	Anemia	❑	❑
Cramps	❑	❑	Bloody stool	❑	❑	Coldness: Hands Feet	❑	❑
Osteoarthritis	❑	❑	Loss of appetite	❑	❑	Varicose veins	❑	❑
Rheumatoid Arthritis	❑	❑	Nausea or vomiting	❑	❑	Depression	❑	❑
Gout ❑right ❑left	❑	❑	Bowel / bladder problems	❑	❑	Nervous	❑	❑
Headaches	❑	❑	Ulcers/Colitis	❑	❑	Anxiety	❑	❑
Neck Pain	❑	❑	Frequency	❑	❑	Irritable/moody	❑	❑
Low Back Pain	❑	❑	Burning	❑	❑	Crying spells	❑	❑
Artificial Bones/Joints	❑	❑	Blood in urine	❑	❑	Insomnia	❑	❑
Chronic Pain	❑	❑	Kidney problems	❑	❑	Sleep problems	❑	❑
Fractures	❑	❑	HIV+/Aids	❑	❑	Alcohol/Drug Abuse	❑	❑
Palpitations	❑	❑	Sexual dysfunction	❑	❑	Chemotherapy	❑	❑
Chest pain	❑	❑	Abnormal menses	❑	❑	Cancer type __________	❑	❑
Osteopenia/Osteoporosis	❑	❑						

Please List any other serious medical condition(s) you have or have ever had: ____________________

____

Dr's. notes: ____________________

Please list anything that you may be allergic to ____________________

Are you taking any of the following medications?

❑Anti-Anxiety ❑Antidepressants ❑Pain Killers (Including Aspirin) ❑Muscle Relaxants ❑Insulin
❑Blood Thinners ❑Birth Control Pill ❑Other ____________________

Family Health History: Please circle those applicable (M=Mother, F=Father, S=Sister, B=Brother, GP=Grandparent

High Blood Pressure	M F S B GP	Diabetes	M F S B GP	Anemia	M F S B GP
Heart Disease	M F S B GP	Asthma, Emphysema	M F S B GP	Arthritis	M F S B GP
Thyroid Disease	M F S B GP	Migraine	M F S B GP	Cancer	M F S B GP
Kidney Disease	M F S B GP	Seizures	M F S B GP	Birthmarks	M F S B GP
Parents living / good health		Parent deceased M F Ages: ______		Cause ____________________	

Past surgical/hospital history:

Type:____________________ Date(s): ____________________

Type:____________________ Date(s): ____________________

HABITS & ACTIVITY

Do you or have you ever smoked? ❑No ❑Yes __________Packs per day Duration_______ ❑Quit: _____ years ago

Do you or have you ever used alcohol? ❑No ❑Socially ❑Daily ❑Rarely Type ______________

Do you drink caffeinated beverages? ❑No ❑Yes _____ cups/day: ❑coffee ❑tea ❑cola ❑decaffeinated __________

Regular Exercise? ❑Yes ❑No Activity and intensity: ____________________

How much water do you drink per day? ________ Do you feel you eat a well balanced diet? ❑Yes ❑No

Are you interested in a complete nutritional profile to assess your specific nutritional needs? ❑Yes ❑No

Drs.Notes:____________________

____

IN THE EVENT OF EMERGENCY

Who should we contact?____________________ Relation ______________

Home Phone: ____________________ Work Phone: ________________

Medical Doctor?____________________ Phone: ____________________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

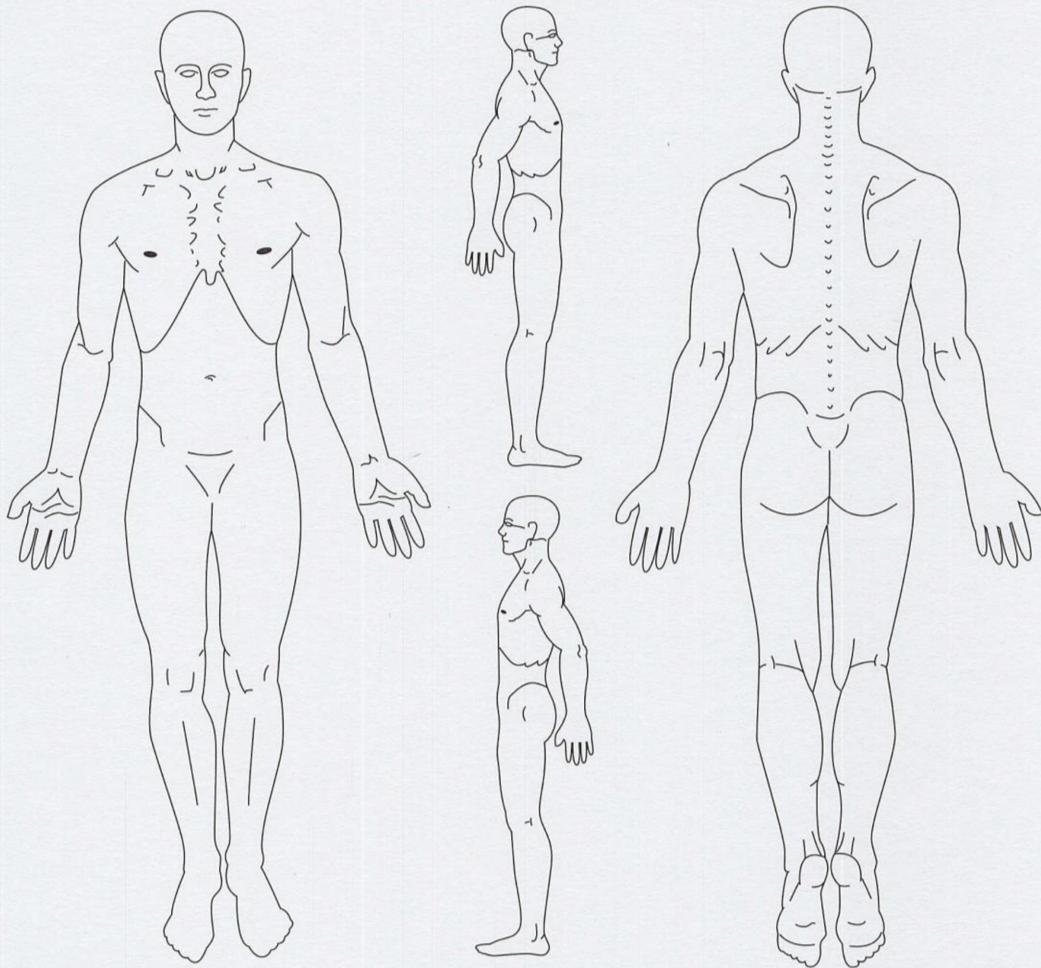
Signature____________________ Date____________________

Patient Name: ____________________

Patient Account: ____________________

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



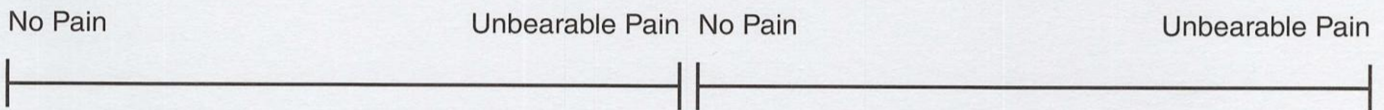
On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

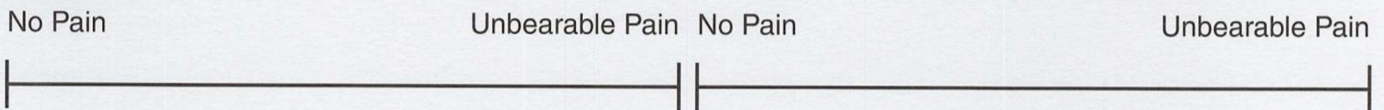


Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain



Patient Name: ____________________

Patient Account: ____________________