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 # (_____) _________Work # (_____) __________ 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 (3 = 70%, 8 = 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:

____

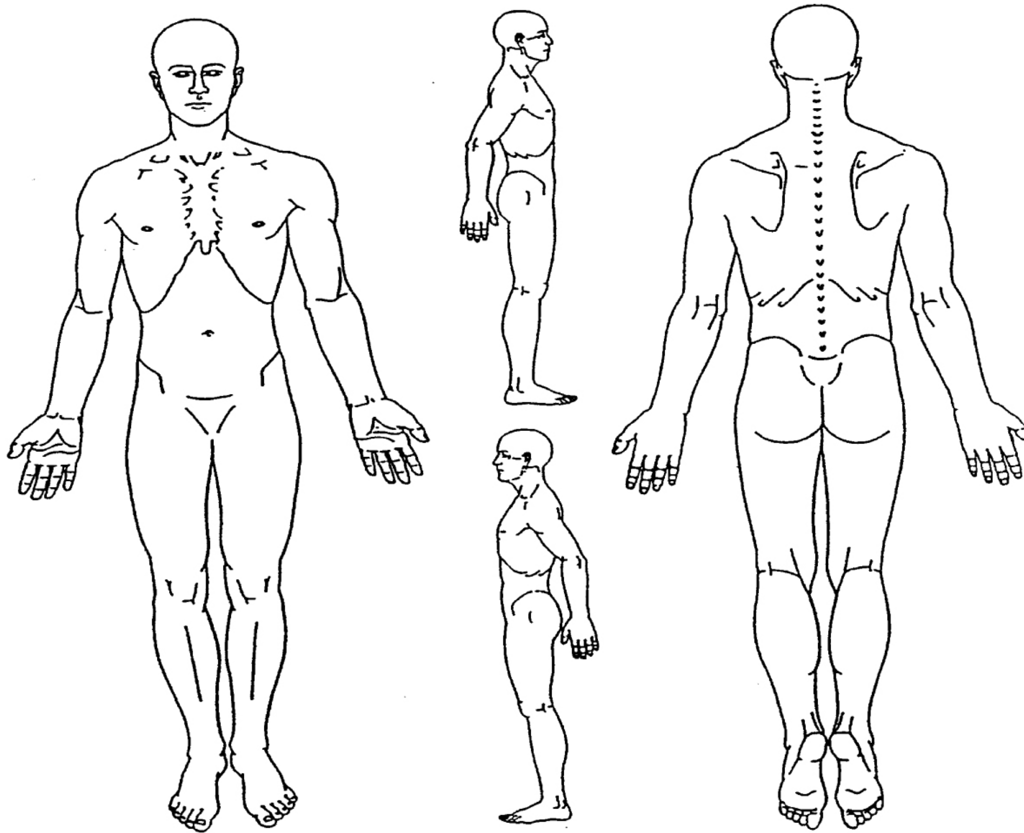
What did you like or not like about your previous treatment experiences?

____

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: ____
____

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 _____