Date _____

Email _____

Home # (_____) _____

Name _____ Social Security # _____-_____-_____ Cell # (_____) _____

Address _____ Cell Phone Carrier _____
(required for text appointment reminders)

City _____ State _____ Zip _____

Age ____ Birth Date ___ /___ /___ Race _____ Marital: M__ S__ W__ D__ How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office # (_____)_____

Spouse _____ Occupation _____ Employer _____

How were you referred to our office? _____

Family Medical Doctor _____

Date symptoms appeared or accident happened _____

How and where did these symptoms occur? _____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe _____

_____

Have you been to another healthcare provider for this condition? ☐ Yes ☐ No If so, where? _____

Are you off work now due to this condition? ☐ Yes ☐ No Total days lost from work _____

Date of last physical exam _____ What surgeries have you had? (include dates) _____

_____

Serious illnesses (include dates) _____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe _____

_____

What medications or drugs are you taking? _____

_____

Please check any and all insurance coverage that may be application in this case: ☐ Major Medical ☐ Workers' Compensation ☐ Medicare ☐ Auto Accident ☐ Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ *Date*_____

Guardian's Signature Authorizing Care _____ *Date*_____

Patient's Name _____ *Date*_____

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? ❑ Work ❑ Sleep ❑ Housework ❑ Family Activities
   ❑ Concentrate ❑ Mood ❑ General Activity ❑ Other_____
3. If this is a recurrence, when was the first time you noticed this problem? _____
   How did it originally occur? _____
   Has it become worse recently? ❑ Yes ❑ No ❑ Same ❑ Better ❑ Gradually Worse
   If yes, when and how? _____
4. How frequent is the condition? ❑ Constant ❑ Daily ❑ Intermittent ❑ Night Only
   How long does it last? ❑ All Day ❑ Few Hours ❑ Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom? ❑ Yes ❑ No
   If yes, describe _____
   Are there other unrelated health problems? ❑ Yes ❑ No If yes, describe _____
6. Describe your symptoms: ❑ Sharp ❑ Dull ❑ Numbness ❑ Tingling ❑ Aching ❑ Burning ❑ Stabbing
   ❑ Annoying ❑ Other _____
7. Is there anything you can do to relieve the problem? ❑ Yes ❑ No If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
8. What makes the problem worse? ❑ Standing ❑ Sitting ❑ Lying ❑ Bending ❑ Lifting ❑ Twisting
   ❑ Driving ❑ Walking ❑Other_____
9. Have you had any broken bones? ❑ Yes ❑ No If yes, please list and give dates _____
   _____
10. List any major accidents you have had other than those that might be mentioned above: _____
    _____
11. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ❑ Yes ❑ No If yes, please explain _____
    _____
12. What is your exercise frequency? ❑ daily ❑ 4-6 days/week ❑ 2-3 days/week ❑ 1-2 days/week ❑ none
13. What type of exercise do you perform? _____
14. Any other health concerns not addressed above: _____
15. Do you smoke? ❑ Yes ❑ No How many packs per day?_____ How long have you smoked? _____
16. Do you drink alcohol? ❑ Yes ❑ No How many drinks per week?_____
17. What do you feel your overall function level is right now? _____% of normal
18. How long (minutes) can you: sit _____ stand _____ walk _____ (please put UL for unlimited) without increasing your discomfort)?
19. Women Only: Are you pregnant or is there any possibility you may be pregnant? ❑Yes ❑ No ❑Uncertain

Patient's Name _____ *Date* _____

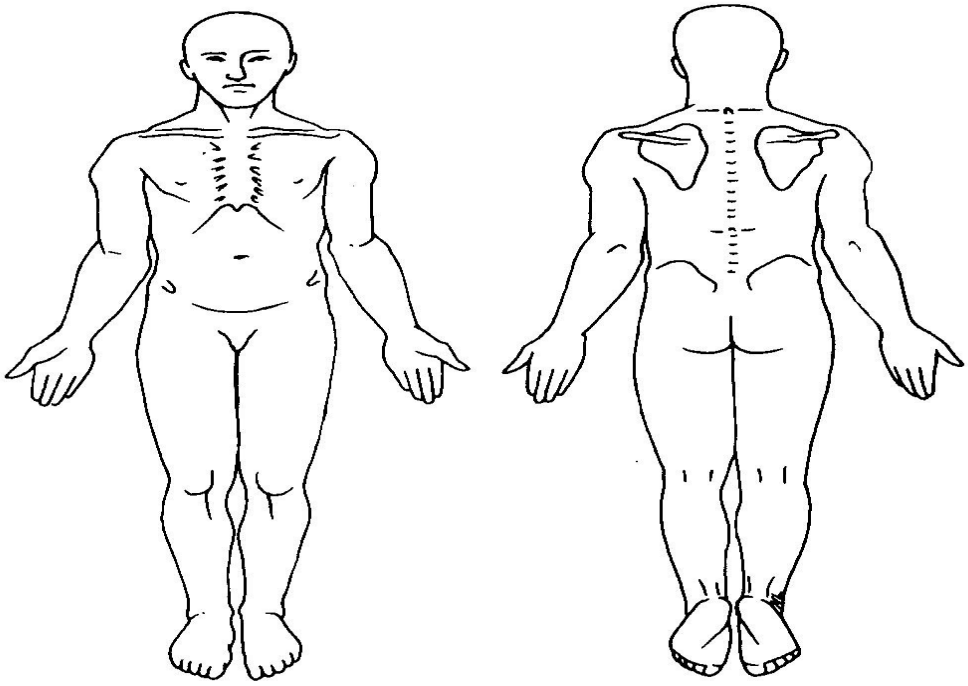
Family History: Check any diseases you or your relatives have had (if known):

Relationship	Spine Problems	Cancer	Diabetes	Heart Disease/ Stroke	Arthritis	Neurological Disease	Prostate Disease
Yourself							
Father							
Mother							
Brother(s)/Sister(s)							
Grandparents							

Please describe the location and type of pain on the diagram below.

Mark the areas on the diagram with the appropriate symbols for the sensations that you feel. Include all affected areas.

Numbness	***Pins and Needles***	***Burning***	***Aching***	***Sharp/Stabbing***
++++	0000	XXXX	****	///////



No Symptoms — Extreme Symptoms

Please place an "X" on the line above to indicate level of pain

Patient's Name _____ *Date* _____

Please check if you have any of the following (more than what you would consider normal):

Musculoskeletal
- ❑ Back Pain
- ❑ Neck Pain
- ❑ Shoulder Pain
- ❑ Knee/Calf/Ankle Pain
- ❑ Elbow/Wrist/Hand Pain
- ❑ Hip Pain
- ❑ Global Muscle/Joint Pain
- ❑ Joint Swelling
- ❑ Jaw pain/TMJ/Teeth Grinding
- ❑ Sciatica

Gastrointestinal
- ❑ Heartburn/Acid Reflux (GERD)
- ❑ Constipation
- ❑ Diarrhea
- ❑ Sour Stomach/Nausea
- ❑ Gas/Flatulence
- ❑ Abdominal /Stomach Pain
- ❑ Bloody Stool
- ❑ Gall Bladder Issues (or removal)

Psycho-Social
- ❑ Excessive Stress
- ❑ Do you worry a lot
- ❑ Do you get angry easily
- ❑ Hard to motivate
- ❑ Depression
- ❑ Anxiety

Respiratory
- ❑ Sinus problems
- ❑ Chronic cough
- ❑ COPD

Cardiovascular
- ❑ High Blood Pressure
- ❑ Previous Heart Procedure/Surgery
- ❑ High Cholesterol

Skin
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dermatitis
- ❑ Lipoma (Fatty Tumor)
- ❑ Dry Skin
- ❑ Easily Bruise
- ❑ Excessive Itching
- ❑ Moles (unusual)
- ❑ Acne

Genitourinary
- ❑ Frequent Urination
- ❑ Prostate Problems (males only)
- ❑ Burning with urination
- ❑ Incontinence

General
- ❑ Sleep Difficulties
- ❑ Unable to relax
- ❑ Frequently get sick
- ❑ Unusual cravings
- ❑ Inflammatory Arthritis (Rheumatoid, Gout, etc.)
- ❑ Autoimmune Disorder
- ❑ Hot Flashes/Flushing
- ❑ Excessive Fatigue/Tiredness
- ❑ Mouth Sores
- ❑ Easily irritated
- ❑ Allergies (seasonal)
- ❑ Allergies (food)
- ❑ Chronic Sinus Issues
- ❑ Dentures
- ❑ Changes in skin color
- ❑ Light headedness
- ❑ Night sweating
- ❑ Ringing in the ears (tinnitus)
- ❑ Excessive Sweating
- ❑ Ear pain
- ❑ Slow wound healing
- ❑ Poor memory
- ❑ Headaches (migraines)
- ❑ Headaches (other)
- ❑ Blurred Vision
- ❑ Mood Swings
- ❑ Hearing Problems
- ❑ Difficulty concentrating
- ❑ Heat/Cold Intolerance
- ❑ Head Feels “Stuffy”
- ❑ Migrating Pain
- ❑ Lower Libido
- ❑ Restlessness
- ❑ Brittle Nails
- ❑ Muscle Cramps
- ❑ Easily Bruise
- ❑ Stomach Ulcer
- ❑ Swelling (“Puffy”) eyes, face, hands or ankles
- ❑ Fullness/bloating in abdomen
- ❑ Irregular menses (females only)
- ❑ Hemorrhoids
- ❑ Strange taste in mouth