

Date _____

Email _____

Name _____ Social Security # ____ - ____ - ____

Home # (_____) _____

Address _____

Cell # (_____) _____

City _____ State _____ Zip _____

Cell Phone Carrier _____
(required for text appointment reminders)

Sex Male Female

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.

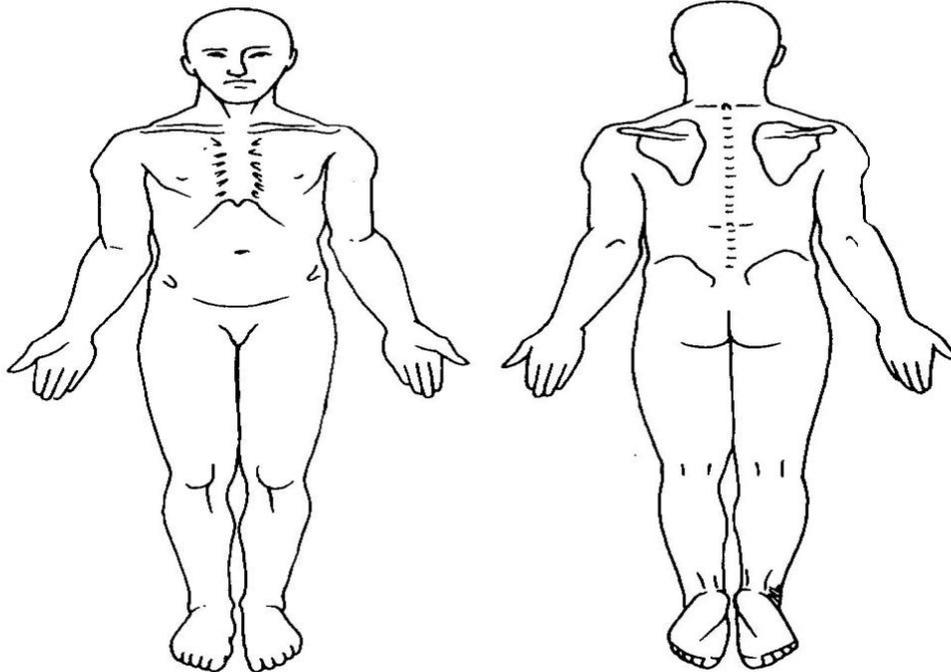
Numbness
++++

Pins and Needles
0000

Burning
XXXX

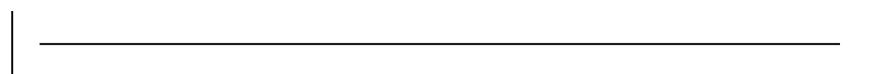
Aching

Sharp/Stabbing
/////



No
Symptoms

Extreme
Symptoms



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

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