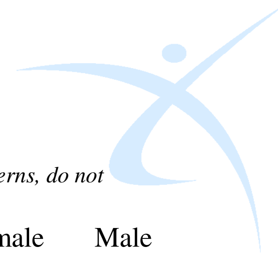


PATIENT_INFORMATION

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

Name ____________________________Date_____________ Date of Birth ______________ Age _____ Female Male

Address ____________________________City ______________ State __________Zip _______ Home phone _______________

Work phone _________________ S/S ______-______-_____ Your employer __________________Occupation_____________

Business Address____________________________________ City ________________________State __________Zip _______

Are you: Minor Married Divorced Widowed Single Separated Do you have children?____________

Spouse or Parent's name ____________________ Person to contact in case of emergency_________________________________

Emergency contact Phone # __________________How did you find out about us? _______________________________________

Email address (office newsletters):____ Date your symptoms began _____________

Type of claim: Cash Group Health Insurance Personal Injury Worker's Comp Medicare

INSURANCE_INFORMATION

Primary *– please present card to receptionist.*

Insurance ______________________________ Primary Insured Name _________________________

Policy #/ SS# ______________________________Date of Birth _____/_____/______

Secondary *– please present card to receptionist.*

Insurance ______________________________ Primary Insured Name _________________________

Policy #/ SS# ______________________________Date of Birth _____/_____/______

CHIROPRACTIC CARE - INFORMED 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. The most common side-effects are of short duration and include local discomfort in the area of treatment, pain, and headache. Most adverse events associated with spinal manipulation are benign and self-limiting. The incidence of severe complications (including but not limited to stroke) following chiropractic care and manipulation is extremely low. The best evidence suggests that chiropractic care is a useful therapy for subjects with neck or low-back pain for which the risks of serious adverse events should be considered negligible (JMPT, 2008 Jul-Aug;31(6):461-4).

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including diagnosis, records, treatment and examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to directly pay the chiropractor for chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered to me or my dependents.

X_________________________________ ____/___/____

Signature of Patient (or parent if a minor) **Date**

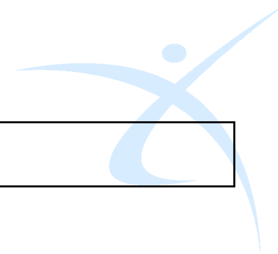
FINANCIAL RESPONSIBILITY

Payment for services are due at the time services are rendered unless other arrangements have been approved in advance by our staff. If you have a co-pay, we will accept that until we have received notice or payment from your insurance company. Your claims will be filed by us as a courtesy. You must realize that your insurance is an agreement between you and your insurance company.

Our fees normally fall within the UCR which is defined as the usual, customary, and reasonable charges for this region. Not all insurances will pay for all services performed at this office. Any unpaid balance not paid by insurance is the patient's responsibility. I fully understand this agreement between this office and myself. I am ultimately responsible for the balance of my account for any professional services rendered.

X_________________________________ ___/___/___

Signature of Patient (or parent if a minor) **Date**



A. COMPLAINTS/CONCERNS

1. Please list your main health objectives or chief complaints.

___

When did you first notice this?________________Describe what the condition feels like______________________________

What do you do for relief? ____

Did something happen?____

___

2. When are your symptoms worse? Morning Afternoon Evening Night Always the same

3. How did your complaint(s) begin? Unknown Suddenly Gradually

4. Check all the appropriate descriptions.

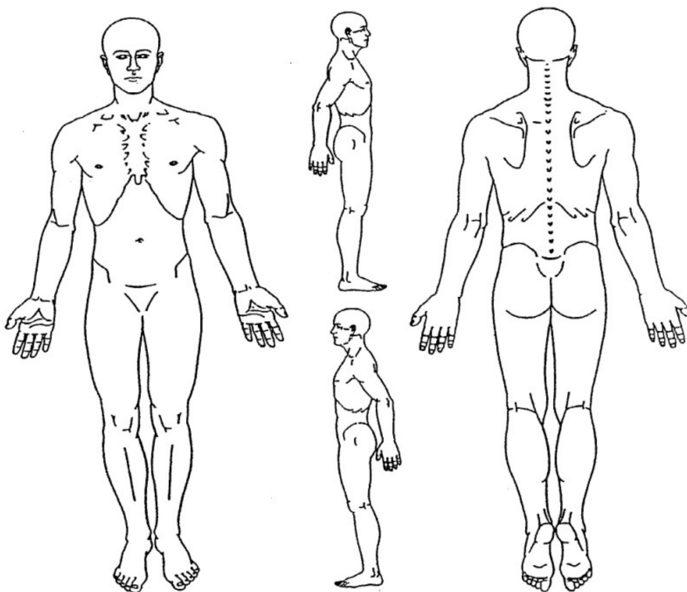
The sensations I feel are:
Pain Numbness Tingling Stiffness Soreness Swelling

The quality of the pain is:
Burning Dull Sharp Shooting Aching Throbbing

The pain duration is:
Occasional Intermittent Frequent Constant

My condition is:
Improving Worsening Unchanged Resolved

5. Indicate on the diagram where you have your complaints.



6. Mark what makes your condition Better or Worse?

B	W		B	W		B	W	
		Bending			Looking Down			Rest
		Exercise			Lying Down			Sitting
		Heat			Medication			Standing
		Ice			Nothing			Stretching
		Lifting			Pull/Pushing			Twisting
		Looking Up			Reaching			Walking
		Laughing			**Coughing**			**Straining At Stool**

7. Have you noticed a change in?
Bowel Function Bladder Function Coordination
Sexual Function Muscular Strength

8. On a scale of 0- 10 rate the severity of your pain today.
If your pain fluctuates please indicate approximately the % of time at each pain level. *Example* 0 1 2 ③ 4 5 6 7 ⑧ 9 10
70% 30%

	No Pain										Worst Pain Possible
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
Headaches	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

9. What happened to cause or re-aggravate your complaint(s)?
Cause Unknown Auto Accident Personal Injury
Work Injury Home Accident Sport Injury
Other – Describe: ______________________________

10. Please circle all areas of previous or current complaints or injuries.

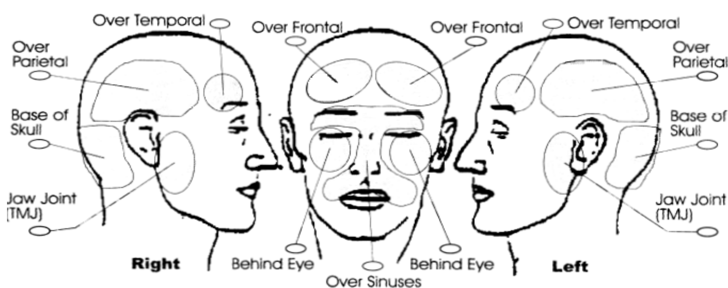
Neck	Uppr back	Mid Back	Low Back	Shoulder	Arm	Elbow	Forearm	Wrist
Hand/Finger	Buttock	Hip	Thigh	Knee	Leg/Calf	Ankle	Foot	Others:

11. Please underline all of the following symptoms you have had previously. Please circle all of the following conditions you have now.

Anxiety	Confusion	Fever (Recent)	Memory Loss
Abdominal Pain	Concussion	Frequent Illness	Menstrual Discomfort
Appetite Change	Constipation (Excess)	Heartburn	Mood Swings
Bed-Wetting	Diarrhea (Excess)	Hernias	Nervousness
Black Tarry Stools	Difficulty Breathing	Impotence	Poor Circulation
Blurred Vision	Difficulty Hearing	Incontinence	Ringing In Ears
Breast Lumps Or Pain	Difficulty Seeing	Insomnia	Skin, Hair Or Nail Changes
Bruise Easy	Difficulty Swallowing	Light Sensitivity	Sinus Trouble
Chills	Dizziness	Loss Of Balance	Swelling
Cold Feet	Enlarged Glands	Loss Of Bowel Control	Urination Painful/Frequent
Cold Hands	Face Flushed	Loss Of Smell	Vomiting (Recent)
Cold Sweats	Fainting	Loss Of Taste	Weight Change
Concentration Loss	Fatigue (Recent)		

B. HEADACHES – If you have headaches fill out this section, otherwise skip to Section C.

1. Where is the pain associated with your headaches?



2. On what date did your headaches begin?

Date: ___/___/___ Same as Neck/Back complaints

3. What describes your pain?

Dull Sharp Deep Burning
Aching Stabbing Vice-Like Throbbing/Stabbing
Other:

4. When do your headaches usually start?

Constant/Anytime Awake Wake up with in morning
At mid-day During evening

5. Do your headaches wake you from sleep?

No Sometimes Always

6. What seems to bring on your headaches?

Physical Activity Caffeine Excess stress
Certain Foods Alcohol Menstruation
Other:

7. How often do your headaches occur?

Times/Week: ⓪①②③④⑤⑥⑦⑧⑨⑩
Times/Month: ⓪①②③④⑤⑥⑦⑧⑨⑩
Other: ________________________________

8. How long do your headaches last?

Less than 1 hour From 1-3 hours
Longer than 3 hours All waking hours
Several hours to days Other

9. Do any of the following occur with your headaches?

Nausea/Vomiting Weakness
Tremor Vision Problems
Dizziness Light/Sound Sensitivity
Other

10. What makes your headaches better?

Nothing Rest
Lying down Ice/cold packs
Massage Standing
Over the counter medications
Other

C. HEALTH HISTORY

1. Please indicate if you or any immediate family member (parent, grand parent or sibling) has experienced the following conditions. Y= you F=family member. Please identify your relationship to the family member on the side.

Y	F	Condition	Y	F	Condition	Y	F	Condition
	☒	Example *sister*			German Measles			Phobias
		AIDS			Gout			Polio
		Allergies			Heart Disorder/Attack			Reproductive Disorder
		Anemia			Hepatitis			Rheumatic Fever
		Autoimmune Disease			High Blood Pressure			Rheumatism
		Bleeding Disorder			High Cholesterol			Scarlet Fever
		Bladder Trouble			HIV/ARC			Scoliosis
		Cancer			Irritable Bowel			Stroke
		Convulsions			Kidney Disorder			Tremors
		Depression			Liver Disease			Thyroid Problems
		Diabetes			Lung Disease			Tuberculosis
		Digestive Disorders			Multiple Sclerosis			Ulcers
		Epilepsy			Muscular Dystrophy			Venereal Disease
		Fibromyalgia			Osteoporosis			Other
		Gallbladder Disease			Paralysis			

2. Have you ever been to a chiropractor? Yes No
Name ____________________

3. Family Physician Information
Date of Last Exam ____________________
Physician's Name ____________________
Location ____________________

4. Have you ever been hospitalized? Yes No
Date and reason for hospitalization: ____________________

5. Have you ever had surgery? Yes No
Date, surgery and results: ____________________

6. Have you ever had a serious injury? Yes No
List Date & Describe Injury:
Auto ____________________
Work-related ____________________
Personal ____________________
Sports Injury ____________________
Other ____________________

7. Have you ever had a fractured bone?
Yes No Please list: ____________________

8. Please give date of last:
X-ray ____________________
Other Imaging ____________________

9. Women Only
To your knowledge, are you pregnant? Yes No
If pregnant in the past were pregnancies normal? Yes No
Are you seeing an OB-GYN regularly? Yes No

10. What are your current habits?

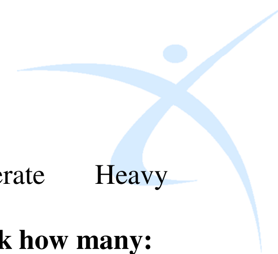
Smoking	Never	Packs Per Day	<1	1-2	>2
Caffeine	Never	Glasses Per Day	<1	1-2	>2
Alcohol	Never	Glasses Per Day	<1	1-2	>2
Drug Abuse	No	Yes			
Exercise	Never	Days Per Week	<1	1-3	>3

11. Kinds of Exercise You Do:
Walking Jogging Cycling Golf Tennis
Strength Training Swim Other:

12. Emotional Health
How would you rate your current emotional health from 0-10?

Worst Possible ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Best Possible

13. Have any of the following occurred recently?
Increased Work Stress Anxiety A Death
Divorce Depression Chronic Fatigue
Economic Stress Job Change Family Problems



14. Have you had any recent treatment for your conditions OUTSIDE of this office?
Yes No If yes, List Dates, Treatments, and Doctors
____
____
____
____

15. Are you currently taking any medications? Yes No
For what condition(s) are you taking medication?
Anti-Inflammatory (Aspirin, Ibuprofen, etc.)______________
____
Pain/Analgesics ______________________________
Anti-Depressants ______________________________
Muscle Relaxers ______________________________
Blood Pressure Pills ___________________________
Antibiotics __________________________________
Birth Control Pills _____________________________
Corticosteroid _________________________________
Other:______________________________________

16. Have you ever used the following?
Birth Control Pills Corticosteroids

17. Are you allergic to seafood or sulfa drugs? Yes No

18. Are you currently taking any vitamins, minerals, or herbs? (List)
____
____

D. OCCUPATIONAL/DAILY ACTIVITIES

1. Are you right or left handed? Right Left

2. In what position do you sleep?
Back Side Stomach

3. Job Type
Full Time Part Time Temporary
Self-Employed __Retired __Unemployed
__ Student (Skip to Patient's Signature)

4. Manual Labor: Light Moderate Heavy

5. During your work week, you work how many:
Hours /Day ⓪①②③④⑤⑥⑦⑧⑨⑩
Days/Week ⓪①②③④⑤⑥⑦⑧⑨⑩

6. How long have you worked in this job?
____

7. Do your present complaints affect the number of hours worked each day? Yes No

8. What is your primary work position?
Seated Standing Other

9. What movements does your job require?
Bending Turning Stooping
Twisting Walking Repetitive Actions
Carrying Other:

10. Does your work include prolonged use?
Computer Phone

11. Does your job involve lifting?
Never Occasional Frequent
Constant
How many pounds: ______________________

12. What is your stress level at work?
Minimal Moderate Extreme

13. Do work activities aggravate your complaints?
Yes No If yes, how? _________________

PATIENT'S SIGNATURE DATE

______________________________ __________

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