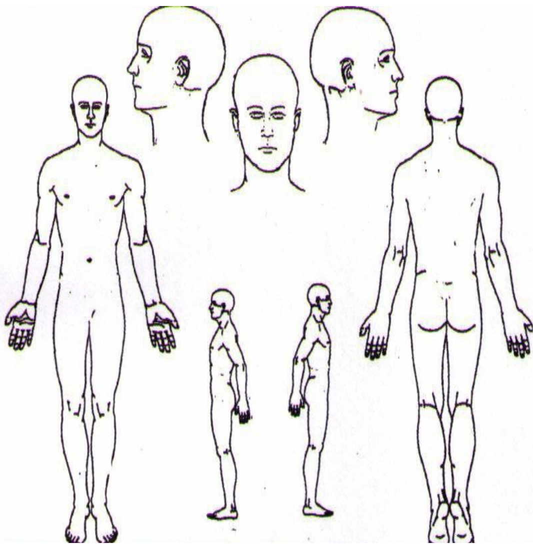
FIRST NAME_____________________ MIDDLE INITIAL_____ LAST NAME ____________________________ ___ MALE ___FEMALE
Address____ City_____________________________________ State _______ Zip__________
Email ______________________________ Phone: HM____________________ WK____________________ Cell ____________________
Best Number To Reach You ___ HM ___ WK ___ CELL Birth Date___________________ Age ____________ # Children _________
___Married ___Single ___Divorced ___Widowed Emergency Contact_____________________________ Tel ____________________
SS#___________________________ Employer ______________________________ Occupation __________________________________
Do you have insurance that may contribute to your care? ___ Y ___ N Are you the Primary Insured (main person on your insurance) ___ Y___ N
If you are not the Primary Insured, please provide the **Name and Birthday of Primary Insured** ______________________________
REFERRED BY ___ Met the Doctor ___ Website ___ Online Search - please list keywords used to find us _________________________
___ Sign/Location ___ Newspaper ___ Other ____
Existing Patient ______________________ Medical Doctor_______________________ Attorney _____________________
____

IF YOU NEED MORE ROOM TO ANSWER ANY QUESTION, PLEASE USE THE BACK OF THIS FORM.
What is your major complaint? (include Left, Right, or Bilateral) ____
____
Does it radiate anywhere? ___ Y ___ N If yes, where? ____
How long have you had this complaint? _______ days / weeks / months / years Have you had this or a similar condition in the past? ___ Y ___ N
Is this condition progressively getting worse? ___ Y ___ N ___ Staying the same Is it: ___ Constant ___Frequent ___Comes and Goes
Circle all that apply: Achy, Dull, Throbbing, Crushing, Sharp, Severe, Stabbing, Burning, Other ____________________________
With 0 = no pain, and 10 = severe, at its best, my pain is a: 0 1 2 3 4 5 6 7 8 9 10 - At its worst, my pain is a 0 1 2 3 4 5 6 7 8 9 10
CIRCLE: This is a NEW / OLD injury and WAS / WAS NOT treated before. If treated before, what was done? ____________________
We attempt to update your other health care providers regarding your condition unless you specifically request that we do not.
Name and Clinic of your other Doctor(s)____
Have you ever had Chiropractic care before? ___ Y ___ N Date of last visit __________ Other complaints? (If you need more space, please write on the back of this form):
____

Please mark each area of pain / complaint with a:
If Left or Right Please circle L or R



Please mark each condition with a C" for Current, and a P" for Past.

______ Neck Problems ______ Sore Muscles ______ Allergies
______ Shoulder Problems- L or R ______ Muscle Cramps ______ Hay Fever
______ Arm Problems L or R ______ Broken Bones ______ Asthma
______ Numbness L or R Arm ______ Frequent Colds ______ Eczema
______ Numbness L or R Leg ______Headaches/Migraines _____ Diabetes
______ Low Back problems ______ Ear Infections _____ Menstrual Cramps
______ Leg Problems L or R ______ Dizziness ______Poor Digestion
______ Pain b/t shoulders ______ Fainting ______Diarrhea
______ Pain in Joints ______ Forgetfulness ______Constipation
______ Loss of Feeling ______ Depression ______Chest Pain
______ Restricts Daily Activities _____ Blurred Vision ______Pain at Night
______ Restricts Exercise ______ Difficulty Breathing ______Blood Pressure
______ Unwanted Weight Gain ______ Difficulty Walking ______ Bowel / Bladder
______ Unexplained Weight Loss _____ Ringing in Ears Circle: High/Low
______ Unusual Fatigue ______ Difficulty Speaking difficulties
______ Nausea / Vomiting ______ Numbness on one side of face or body
______ Difficulty Swallowing ______ Neck or Head Pain like never before
______ Other ____

Family Health History: Please list any condition (including those listed above) that your father, mother, spouse, brothers, sisters, or children have, or have had in the past. ________
____
____

Please rate how your pain / symptoms / health problems affect your Activities of Daily Living. Rate on a scale of 1-10, with 0 = No Problem to do / participate in the Activity, and 10 = extreme pain or problems doing the activity. If an Activity of Daily Living category does not apply to you, please leave it blank.

______Bending ______Carrying ______Concentrating ______Dancing
______Doing Chores ______Doing Computer Work ______Dressing Driving ______Gardening
______Lifting ______Performing Sexual Activity ______Playing Sports ______Pushing
______Reading ______Recreating ______Rolling Over ______Running
______Shoveling ______Sitting to Standing ______Sitting ______Sleeping
______Standing ______Walking ______Watching TV ______ Working
______Climbing ______Playing with kids/grandkids ______Other (please list) _________________________________

Sign ____ Date ______________________

Last time you had Spine X-rays ___________________________________

FEMALES: Are you pregnant? ___ Yes ___ No ___ Not sure

From past to present, please list by date and describe

1. Car Accidents ____
____
____

2. Falls / Injuries (Including Sports) / Work trauma (with date of trauma)
____
____
____
____

Medications and Supplements you now take ________________
____
____
____

Any known allergies to Medications / Supplements? ___ Y___ N

(If yes, please explain)___________________________________
____
____

List all surgeries you've had (with date of surgery) ____________
____
____

As a holistic, wellness-oriented office, it is our desire to help you improve every aspect of your life as it relates to your health.

How would you rate your diet? ___Poor ___Fair ___Good ___Excellent

How would you rate your exercise? ___Poor ___Fair __Good __Excellent

Please rate your stress levels on a scale of 1 to 10 with 1 = low and 10 = high ___Personal Stress ___Job Stress ___Other stress

Is there anything else you want the doctor to know? ___Y ___ N If yes, please state it here: ____
____
____

Sign ____ **Date** ____________________

(Parent to sign if under 18)

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on (child's name):________________________________, by the licensed doctors of chiropractic, medical doctors, licensed physical therapists, and / or the doctor's trained representatives who may be employed by or engaged in practice in this clinic.

If I have questions regarding informed consent, I will discuss with the doctor(s) the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes very rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had or will take the opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By initialing this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Initials:_____________Date of last menstrual period _______________________.

HIPPA and Notice of Privacy Practices

I have been given a copy of and / or have access to the clinic's Notice of Privacy Practices which discusses how my PHI (Personal Health Information) will be used for diagnosis, treatment, and payment on my account.

______________________________________ ____ ______________

Patient's Name (Print) **Patient's Signature** **Date**

______________________________________ ____

Relationship /authority if not signed by Patient **Witness**