

Introduction and History

Date: _____

| | |
|---|--|
| Name: | Date of birth (Month/Day/Year): |
| Home Address and Phone Number: | Employer and Work Phone Number: |
| E-Mail: | Occupation: |
| Cell Phone: | Social Security Number |
| Family Medical Doctor: | Referred by (please include person's name): <input type="checkbox"/> Friend/Family <input type="checkbox"/> M.D. / D.C. <input type="checkbox"/> Internet/Add |
| Have you had Chiropractic care before? If so, when and by whom? | Children's Name and Ages: |
| Spouse's Name and Occupation: | Hobbies: |
| Please circle sex: Male Female | |

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible Chiropractic care, we will need to discover any '**stresses**' that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting this office

Wellness / Prevention Care - *I wish to continue my Chiropractic Wellness Care.* Just answer the following questions that apply.

Please describe your current problem, including the effect it has had on your life:

Please describe the character of your pain (check all that apply)

- Sharp/Stabbing Sharp/Dull Achy Dull Soreness Weakness
 Throbbing/Gnawing Numbness Shooting Gripping/Constricting
 Burning Tingling Other: _____

PLEASE TURN OVER g

Your name: _____

How often are the complaints present?

Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

When is the pain or symptoms worse:

When you wake up During the day After work In the evening After eating
 While sleeping

How bad is your pain or ache? Please circle a number (0= no pain, 10 = unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

Since your problem began is the pain : increasing decreasing not changing

When did your problem begin: _____ (specific date if possible)

Please draw on the diagram where you feel your symptoms: **g**

Do you sleep on your:

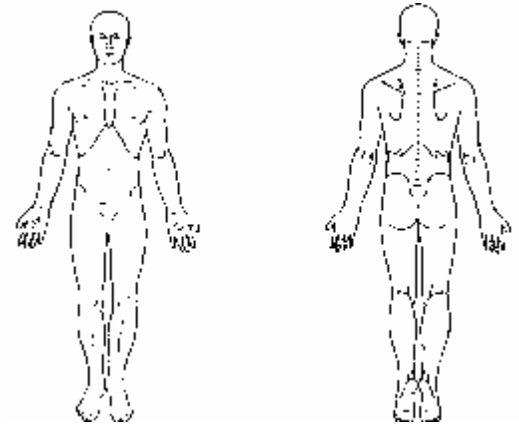
Back Stomach Left Side Right Side

Physical Activity at work:

Sitting more than 50% Light manual labour
 Heavy manual labour

General physical activity:

No regular exercise program
 Light exercise program
 Strenuous exercise program



How would you rate your stress level:

No Stress Minimal Stress
 Moderate Stress Greatly Stressed

Do you currently smoke? Yes No. If YES please indicate how many packs a day: _____

Number of years: _____

Who else have you seen for this condition: _____

Please describe any falls, auto accidents or major injuries (include Month/Year, Type of accident):

Please describe any and all past surgery: _____

Please list ANY and ALL medication (prescription and over the counter): that you are currently taking: _____

Please Circle Any That Apply: PERSONAL HISTORY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: _____

Please Circle Any That Apply: FAMILY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: _____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Buzzing/Ringing in Ears | <input type="checkbox"/> Lungs | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Eyes/Vision | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach | <input type="checkbox"/> Leg Pain/Cramps |
| <input type="checkbox"/> Concentration Loss | <input type="checkbox"/> Sinus | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Bladder | <input type="checkbox"/> Numb Feeling |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Liver | <input type="checkbox"/> Feeling of Pins/Needles |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Colon | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Loss Energy | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Kidney | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tired Mornings | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Menstrual Pain/Irregularity | <input type="checkbox"/> Urination | <input type="checkbox"/> Fever |

- Do you drink bottled or filtered water: Yes No
- Do you belong to a health club or exercises regularly: Yes No

If you remember the details, what was your birth delivery like (eg – breach, c section, long): _____

Have you had any or all of your childhood vaccinations? All Some: _____

Any reactions to vaccinations? _____

Please list all supplements and vitamins you take: _____

How would you rate your health:

Yuk I've never felt worse
1 2 3 4 5 6 7 8 9 10
Wow I feel great!

How committed are you to improving your health:

Nah, not important
1 2 3 4 5 6 7 8 9 10
I want to be 100% healthy!

Do you want to live to be a healthy 85 years old? Yes No

What is 'being healthy' to you (check all that apply)?

- | | |
|---|--|
| <input type="checkbox"/> Not being sick | <input type="checkbox"/> Being symptom free |
| <input type="checkbox"/> Having energy to do what I want, when I want | <input type="checkbox"/> Not needing to take time off work |
| <input type="checkbox"/> To fully enjoy all aspects of life to the fullest extent possible. | |

What is your goal or expectations with Chiropractic care: _____

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Care and Nutritional Care, and I give authority for these procedures to be performed. I have been informed of the Clinic's financial policy and agree that I am responsible for all bills incurred at this office. I have had an opportunity to review the privacy policy and agree to its terms.

Patient/Guardian Name: _____

Patient/Guardian Signature _____ Date: _____

A word about our financial policies:

Our recommendations are based solely on the difficulty of your case and are never influenced by your level of insurance coverage.

All charges will be discussed with you and agreed upon, before any service will be provided.

Payment is expected on the day services are rendered unless other arrangements have already been agreed upon.

Practice members who are committed to their care programs will never be denied treatment. We have many programs which make our care affordable to those who are committed to achieving optimal health.

PLEASE ANSWER ALL QUESTIONS! Please print clearly.

1. Who is responsible for this account? _____

2. Relationship to practice member

3. Do you have insurance coverage? -

a. If yes, subscriber's name

b. Date of birth _____ c. Social Security number

4. Do you have secondary coverage?

a. If yes, subscriber's name

b. Date of birth _____ c. Social Security number

5. **How would you like to pay for your 1st visit?** Please circle one

- a. Cash b. Check c. Credit Card
d. Debit Card w/Visa,MC, Discover, AmEx.

PATIENT'S SIGNATURE _____

DATE _____