WELCOME TO OUR OFFICE

Personal Information: Today's Date: _____/_____/_____ File #: ____________________

Name: ____

Birth date: _____/_____/_____ Age: __________ SSN: ____________________________

Gender assigned at birth: □ Male □ Female □ Prefer not to say

Home Address: ____

City: ______________________________________ State: ____________ Zip Code: ______________________

Home Phone: ________________________________ Cell: ____

E-mail address: (for monthly newsletter/correspondence only) ____

How did you hear about us? □Referral □Mail □Location □Internet □Walk-in □Insurance □Other __________

Who may we thank for referring you to our office? ____

Relationship Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Emergency Contact: _____________________________________ Phone #: ___________________________

Relation: ________________________

Medical Physician's Name: ________________________________ Last Visit: ___________________

Insurance Information:

Do you intend to use health insurance? □ No □ Yes Are you covered by: □ Medicare

Please allow our front desk staff to copy your insurance card and drivers' license

Account Information:

Person ultimately responsible for account: ☐ Same as listed above (if different please complete below)

Name: ____ Relation: _______________________________

Billing Address: ____

City: ______________________________________ State: ____________ Zip Code: ______________________

SSN: ______________________________________ D.L. # ____

Home Phone: _______________________________ Work Phone: __________________________________

Payment Information:

PLEASE NOTE: On your first visit, payment is due in full at the time of service, unless prior arrangements were made. We **DO** accept insurance assignment, but **NOT** until we are able to contact your insurance carrier directly to verify benefits. Payment you make today which is verified to be covered by insurance will be credited to your account or reimbursed upon your request.

Based on this, payment today will be: _____Cash _____Check _____Credit Card (Visa, MC)

I authorize the doctor to evaluate and care for me as he/she deems appropriate. I understand and agree that all services rendered me at this office are my financial responsibility and are charged directly to me. Even if submitted to insurance, ultimately, I am personally responsible for payment.

Patient's Signature ____ Date: _____/_____/_____

Parent/Guardian Signature ______________________________________ Date: _____/_____/_____

Name: **File #:** **Date: / /**

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ______________________

____

List any past conditions you may have had: ____

HABITS		EXERCISE	FAMILY HISTORY	Diabetes	Cancer	Back Pain	Other
❑Smoking	Packs/day: _____	❑None					
❑Drinking	Alcohol: (Cups/day): _____	❑Moderate	Mother	❑	❑	❑	❑_________
❑Coffee	Cups/Day: _______	❑Daily	Father	❑	❑	❑	❑_________
❑Soft Drink	Bottles or Cans/Day: _____	Type: _________	Brother(s)	❑	❑	❑	❑_________
❑Water	Cups/Day: _______	______________	Sister(s)	❑	❑	❑	❑_________

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? ❑Yes ❑No
If yes, which ones?: ____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _______________________________

Do you have allergies? ❑Yes ❑No If yes, please explain: ____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_________________	Back Operation	_________________	Hernia	_________________	Gall Bladder
_________________	Female Organs	_________________	Thyroid	_________________	Stomach

Other ____

Have you ever had X-rays taken? ❑Yes ❑No When? ___________________ By Whom? ____________________________

For what ailments were these X-rays taken? ____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS
- ❑ Allergy(What) ____ _________________
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache

GASTRO-INTESTINAL
- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea

EYE/EAR NOSE/THROAT
- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction

RESPIRATORY
- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY
- ❑ Bed Wetting
- ❑ Blood in Urine

Name: **File #:** **Date: / /**

GENERAL SYMPTOMS
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

MUSCLES & JOINTS
- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors
- ❑ Twitching

GASTRO-INTESTINAL
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

CARDIO-VASCULAR
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

EYE/EAR NOSE/THROAT
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

SKIN OR ALLERGIES
- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

GENITO-URINARY
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

FOR FEMALES ONLY
- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?
- ________ Last Pap Date
- ________ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

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Name: **File #:** **Date: / /**

REASON FOR VISIT: ***(Please complete the following in detail. We will review this info during your consultation)***

****** If you check YES please explain in detail ******

Have you had previous chiropractic care? □ No □ Yes ______________________________

What is your major **spinal related** health concern? ______________________________

Do you have any other health concerns? □ No □ Yes ______________________________

How did condition develop? ______________________________

How long have you been suffering with this health problem? ______________________________

Have you had same or similar problems in the past? □ No □ Yes ______________________________

Is this problem getting worse? □ No □ Yes ______________________________

How long has it been since you really felt healthy? ______________________________

What makes the problem worse? ______________________________

What makes the problem better? ______________________________

How would you describe the symptoms? □Sharp □Dull □Ache □Throbbing □Burning □Other ___________

What percentage of time does this condition bother you? □ 0% □ 25% □ 50% □ 75% □100%

Does it wake you up at night or keep you from getting rest? □ No □ Yes ______________________________

How would you rate the level of discomfort on a scale of 0-10 (0 = no pain / 10 = extreme pain)? ______________

Does the condition travel to other parts of your body? □ No □ Yes ______________________________

Time of day condition seems to be at its worse? Morning / Afternoon / Evening / Night ______________________

Have you had any recent falls/accidents/injuries? □ No □ Yes ______________________________

Have you had any accidents/injuries in the past? □ No □ Yes ______________________________

How does this condition impact or limit your life/daily activities? ______________________________

Others who have treated you for this condition? ______________________________

Additional information regarding your health. ______________________________

Name: **File #:** **Date: / /**

Employment, ADL, and Recreation Information

Daily Activities: Effects of Current Condition on Performance:

Activity	Doesn't Hurt at all	Hurts a little	Hurts very much	Almost unbearable	Unbearable pain prevents activity
Walking					
Sitting					
Bending					
Standing					
Sleeping					
Lifting					
Running/Jogging					
Climbing stairs					
Carrying					
Pushing/Pulling					
Driving					
Dressing					
Reading					
Watching TV					
Household chores					
Gardening					
Sports					
Employment					

Please select up to three activities that affect you the most during your daily activities. Then indicate how long you can perform the activity before you had the pain and how long you can now perform the activity with your pain.

Ex: Walking: Before I had the pain, I could walk for 1 hour without any pain and now I can only walk for 10 minutes. Activity is walking. Normal is walking for 1 hour. Walking is now limited to only 10 minutes before having pain.

Ex: ____Walking____________ ______1 hour_____________ _________10 Minutes_________

Activity **Normal** **Limitation**

1. ________________________ ________________________ ________________________

2. ________________________ ________________________ ________________________

3. ________________________ ________________________ ________________________