



Date: _____

Patient #: _____

Name: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

E-mail Address: _____

DOB: _____ Marital Status: M W D S Spouse's name: _____

Children's Name & Ages: _____

Occupation: _____ Employer: _____

Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? _____

Research shows that a spine should be checked regularly. Have you seen a chiropractor in the past? Yes / No

How regularly were you getting adjusted by your previous chiropractor? _____

Who is your medical doctor(s)? _____ Clinic name and city: _____

Insurance Information

If you are insured and wish for us to assist you in submitting claims, please provide us with your insurance card so that we may verify how your provider participates with chiropractic care in this office.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Briefly describe the chief area of complaint(s), including the effect that it has had on your life:

Since the problem started, is it: Getting better The same Getting worse

Does it interfere with: Work Sleep Walking Sitting Hobbies Leisure Family time

When did it first appear? _____ Have you experienced it in the past? Yes / No

Has anyone in your family experienced similar problems? Yes / No If so, who? _____

Doctors seen for this problem: Chiropractor Yes / No Medical Doctor Yes / No Other: _____

Do you suffer from any condition other than that which you are now consulting us? Yes / No Please explain:

BODY SIGNALS

Please circle **ALL** symptoms (body signals) you have had in the past year, even if they do not seem related to your current problem:

- | | | | | |
|--------------------------|--------------------------|----------------------|------------------------|--------------------|
| Headaches | Loss of smell | Fainting | Neck pain | Cold sweats |
| Pins and needles in arms | Pins and needles in legs | Back pain | Loss of balance | Mood swings |
| Dizziness | Buzzing in the ears | Ringling in the ears | Nervousness | Light bothers eyes |
| Numbness in fingers | Numbness in toes | Loss of taste | Stomach upset | Heartburn |
| Fatigue | Depression | Irritability | Tension | Hot flashes |
| Sleeping problems | Stiff neck | Fever | Ulcers | Cold hands & feet |
| Diarrhea | Menstrual pain | Problems urinating | Menstrual irregularity | Constipation |

Stress can cause or accelerate spinal damage. Rate your level of stress over the past 90 days: < 1 2 3 4 5 6 7 8 9 10 >

Poor posture leads to poor health and often indicates a spinal condition.

How would you rate your posture? Poor < 1 2 3 4 5 6 7 8 9 10 > Excellent

Prescription medication may cause various side effects, hide the severity of health conditions and/or hinder the body's ability to heal. What medications are you currently taking? _____

Your nervous system consists of your **brain, spinal cord, and nerves**. Have you ever seen a doctor (or been prescribed medication) specifically for any issues related to your nervous system? _____

Which vitamins or supplements are you currently taking? _____

What do you like to do for fun?! _____

What are your overall health and wellness goals?

PAST MEDICAL HISTORY (Check ones that you have had in the past)

- | | | | | |
|-------------------------------------|------------------------------------|--|--|--|
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tumor | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Polio | <input type="checkbox"/> Skin trouble | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parasites | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Dysentery | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Migraine | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Angina | <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Kidney infections |

For women only: Is there a chance that you could be pregnant? Yes / No

FAMILY HISTORY (If mom dealt with it, put an M. If dad, put a D. If both, put a B.)

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures/convulsions | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Arthritis/rheumatoid | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Circulation problem | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke (include age) | <input type="checkbox"/> Other: _____ |

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of improving their health and working toward their health goals listed above. 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 invite 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 health records, please inform our front desk. Thank you!

Patient signature: _____ Date: _____