Welcome To Our Office!

(PLEASE PRINT) Date_____

Name_____

Address _____ City, State, Zip_____

Home Phone # _____Cell Phone #_____ email:_____

Your Occupation_____ Employed By_____

Social Security #_____ Birth date _____ Age_____ Sex_____ No. of Children_____

Marital Status (circle) – M S D W Spouse's Name or Parent_____

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

Have you ever had Chiropractic Care before? _____If so, when?_____

List your chief complaints in order of severity:

(1)_____For how long?_____

(2)_____For how long? _____

(3)_____For how long? _____

List other doctors consulted for these conditions:

(1)_____Address_____

(2)_____Address_____

Is this injury or illness work-related? _____ Have you reported it to your employer?_____

Is this injury or illness related to an automobile accident? _____(If yes, name of:)

Your Auto Ins. Co. _____ Policy #_____ Claim #_____

Adjustor's Name _____ Adjustor's Phone # _____

List any accidents or falls and dates: □ Car _____ □ RV _____□ Sports _____

□ School _____ □ Other _____ (Explain) _____

List any broken bones (fractures) or dislocations: _____

Have you ever had X-rays, MRI, and or CT scans taken? □ Yes □ No When? _____ Where? _____

For what ailments were these X-rays made?_____

Are you presently taking any medication - prescription or over-the-counter? □ Yes □ No What drugs?_____

_____

Do you suffer from any condition other than that for which you are now consulting us?_____

(continued on other side)

Surgery (Please include all surgery)

(1) Type _____ When _____

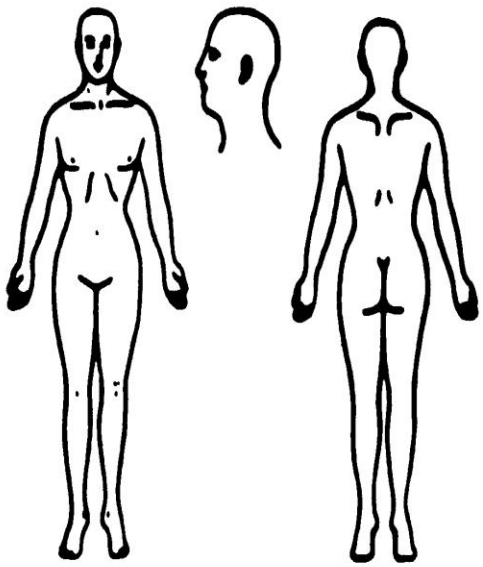
(2) Type _____ When _____

(3) Type _____ When _____

ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

- ❑ Stroke
- ❑ Fatigue
- ❑ Migraine
- ❑ Nervousness
- ❑ Arthritis
- ❑ Numbness or pain in arms/legs/hands
- ❑ Pregnant at this time
- ❑ Pain between shoulders
- ❑ Spinal curvature
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Headache
- ❑ Shingles
- ❑ Dizziness
- ❑ Heart attack
- ❑ Cancer
- ❑ Diabetes
- ❑ Sinus
- ❑ Stiff neck
- ❑ Backache
- ❑ Swollen joints

Please mark your areas of pain on the figures below.



0——————— 5 ———————10

Please rate your pain: 0 Absent to 10 Extreme

Are symptoms

❑ Getting worse ❑ Getting better ❑ Staying the same

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic care as deemed necessary for my child.

Parent's Signature: **X** _____ **Date**: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge having received a copy of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Signature: **X** _____ **Date**: _____

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X _____ **Date:** _____