## PATIENT INFORMATION

Name: ______________________________________________________ Gender: M F

Home Address: ____________________________________________ Apt: ____________________

City, State: _______________________________________________ Zip: ____________________

Home/Cell Phone: ( ) ____________________ Work Phone: ( ) ____________________

Email Address: ______________________________________________________________________

Birth Date: ______ / ______ / _______ Social Security #: ________ - ______ - _________

Employer: ________________________________ Occupation: _______________________________

Marital Status: ☐S ☐M ☐D ☐W

Spouse's Name: _________________________ Work/Cell Phone: ( ) ____________________

Occupation: __________________________________________________________________________

Do you have children? ☐Y ☐N

Emergency contact: _______________________________ Phone #: __________________________

Who may we thank for referring you to our office?

_____________________________________________________________________________________

Reason(s) for visit:__________________________________________________________________

When did this start? ____/____/________ ☐Episodic (on and off) ☐Sudden ☐Progressive

## IDENTIFY SYMPTOMS

☐ Back Pain ☐ Mood Swings ☐ Low libido ☐ Neck pain ☐ Numbness/tingling

☐ Painful joints ☐ Headache ☐ Fatigue ☐ Heartburn ☐ Loss of smell/taste

☐ Depression ☐ Sciatica ☐ Irritability ☐ Fevers/Chills ☐ Light bothers eyes

☐ Tension ☐Ringing in ears ☐Ulcers ☐ Low energy ☐ Upset stomach

☐ Depression ☐ Urination problems ☐ Pins and Needles ☐ Weight gain/loss

☐ Frequent colds/flu ☐ High/low blood pressure ☐ Menstrual Pain ☐ Constipation/Diarrhea

☐ Dizziness/Balance ☐ Insomnia/sleep problems ☐Cold Hands/Feet ☐Nervousness/anxiety

☐ Other ____________________________________________________________________

List any medicatons____________________________________________________________

**What activities aggravate your symptoms?**

☐ Walking/running ☐ Sitting ☐ Bending ☐ Concentrating

☐ Dancing ☐ Sleeping ☐ Computer work ☐ Playing sports

☐ Watching TV ☐ Lifting ☐ Pushing ☐ Reading

☐ Rolling over ☐ Driving ☐ Other ____________________

**If experiencing spinal pain, please provide additional details below:**

☐ Neck ☐ Upper back ☐ Mid back ☐ Lower back ☐ Other

**Quality of pain:**

☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Spasm ☐Numb ☐Tingling ☐Shooting

**Does the pain radiate into your:** ☐Arm ☐Leg ☐Does not radiate

**On a scale of 1-10, what's your level of pain when it's at its worst?** _________________

**How often do you experience these symptoms throughout the day?**

☐100% ☐75% ☐50% ☐25% ☐10% ☐Only with Activity

**Does complaint(s) interfere with:** __ Work __ Sleep __ Hobbies __ Daily Routine

**Have you suffered from this problem (or similar) in the past?** ☐Yes ☐No

**If yes,** how often: ___________________ When was the last episode**:** ______________________________

**Have you tried other forms of treatment?** ☐Yes ☐No

**If yes,** please state type of treatment: _________________________________________________________

Who provided treatment: __________________________________ How long ago: __________________

What were the results: ☐Very favorable ☐Favorable ☐Neutral ☐Unfavorable

Explain: _______________________________________________________________________________________

**Have you been diagnosed with any of the following conditions:**

☐ Heart disease ☐ Depression ☐ Diabetes ☐ Immune/Auto-immune issues

☐ Cancer ☐ Bone disease ☐ Thyroid problem ☐ Diabetes

☐ Irritable Bowel Syndrome (IBS) ☐ Restless Leg Syndrome (RLS) ☐ Scoliosis

☐ Other ___________________

**Any additional conditions your doctor should be made aware of (medications, history, etc)?**

_______________________________________________________________________________________________

_______________________________________________________________________________________________

**This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate that you have been made aware of its availability:**

**Initials** ________

**The Statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.**

**Patient Signature** _____________________________________________ **Date:** ______________________

**Guardian Signature**_____________________________________________ **Date:**_______________________

**Regarding:** Chiropractic Adjustments and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, may pose certain risks. While the risks are generally very minimal, in rare cases, complications, such as sprain/strain injuries, irritation of disc conditions, and although extremely rare, minor fractures.

Treatment objectives as well as possible risks associated with chiropractic adjustments and all other procedures provided at Palm Beach Health Center have been explained to my satisfaction, and I have conveyed my understand of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method and/or techniques that the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

| ________________________________________ | ____/____/ ____ | _____________ |
|---|---|---|
| Patient or Authorized Person's Signature | Date | Witness Initials |

**Regarding:** X-Rays/Imaging Studies

FEMALES ONLY: Please read carefully and check the two statements below, include the appropriate date, then sign below if you have no further questions. Otherwise, please see the front desk for further explanation.

____________ The first day of my menstrual cycle was _____/ _____/ _____
Initial Date

____________ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.
Initial

By my signature below I acknowledge that the doctor and or a member of this staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, therefore, I do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

| __________________________________________ | _____/ _____/ _____ | _____________ |
|---|---|---|
| Patent or Authorized Person's Signature | Date | Witness Initials |