

ABOUT THE PATIENT

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ ZIP _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Significant Other's Name _____ Kid's Names and Ages _____
 Your Employer _____ Type of work: _____
 E-mail Address _____ Have you been to a chiropractor before? Yes No
 Emergency Contact _____ Ph#: _____
 Name of Medical Doctor(s) _____ Insurance Co. _____

- I authorize the doctor or her staff to render care as deemed appropriate for me and/or my child.
- I authorize the release of any medical records or other information needed to process my insurance claim.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits to the provider for services shown on the insurance form.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance, my preferred payment method is: Cash Check Credit Card Car/Work Insurance

Patient/Parent Signature (Represents a long term authorization for all occasions of service) **Date**

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the Same Getting Worse
 Mild Moderate Severe Worse in the morning Worse in the evening Pain radiates to _____
2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the Same Getting Worse
 Mild Moderate Severe Worse in the morning Worse in the evening Pain radiates to _____
3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the Same Getting Worse
 Mild Moderate Severe Worse in the morning Worse in the evening Pain radiates to _____
4. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the Same Getting Worse
 Mild Moderate Severe Worse in the morning Worse in the evening Pain radiates to _____
5. Does your condition affect: Sleep Work Daily Routine Sitting Driving _____

6. What makes you feel better? _____

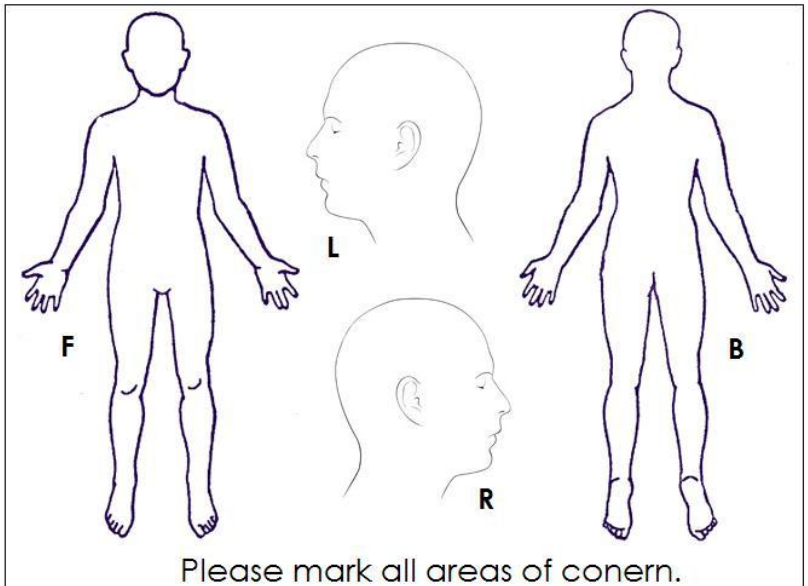
7. What makes you feel worse? _____

8. What doctors have you seen for this? _____

9. Type of treatment: _____

10. Results: _____

NOTES: _____



GENERAL HEALTH HISTORY

Patient Name _____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems
<input type="checkbox"/>	<input type="checkbox"/>	Medication Side Effects	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinner use
<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands or Feet	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Trouble Walking	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Leg/Foot Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	___ High or ___ Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	Stroke History
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	TMJ
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pain all over
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tension/Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Light Bothers Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

- List any medications you are taking: _____
- Please list all doctors you are currently seeing: _____
- Has any doctor or other professional advised you to "go to a Chiropractor"? No Yes Name _____

PAST HISTORY

- List any past auto collisions: _____ Was any care received? _____
- List any past work injuries: _____ Was any care received? _____
- List any past sport, recreational, or home injuries: _____
- Please describe any past conditions and treatment received: _____
- Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

- Father's side: Heart Disease Cancer Diabetes Heavy Medication Use Arthritis Other _____
- Mother's side: Heart Disease Cancer Diabetes Heavy Medication Use Arthritis Other _____
- Is there any other family history you want us to know?: _____