

ABOUT YOU

First Name _____ Middle Name _____

Last Name _____

Street Address _____

Line 2 -
Apartment
Number _____

City _____ State _____ Zip _____

Mobile Phone ____-____-____ Work Phone ____-____-____ Home Phone ____-____-____

Email _____

Date of Birth ____ / ____ / ____ Gender Male Female

Height ____' ____" Weight _____ lbs

Marital Status Single Married Separated Divorced Widowed Other

Number of Children _____ Spouse's Name _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-____ Relation To You _____

REFERRAL INFORMATION

Referring Physician _____ Contact information. _____

Referring Patient _____

Are you working with an attorney? Yes No

How did you hear about us?

Word of mouth Advertisement Social media Direct marketing Internet

REASON FOR VISIT

What is the date of your scheduled appointment? _____ / _____ / _____

How long have you had this complaint?

- Less than 5 days (Acute)
- Between 5-30 days (Sub Acute)
- More than 30 days (Chronic)

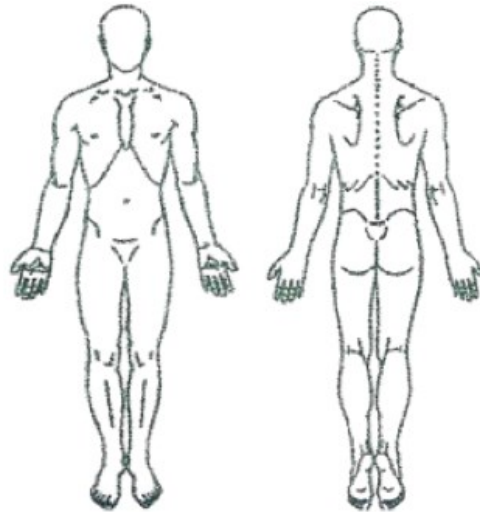
What caused this condition _____

What is the date this condition began? (Skip if due to accident) _____ / _____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

- P - pain
- N - numbness
- W - weakness
- S - shooting
- A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How often do you feel this discomfort? Constant Frequent Occasional Intermittent

How has this complaint changed since the onset? Worsened Remained the same Improved

What activity is most significantly affected by this discomfort? (Explain) _____

What treatment, if any, have you received since the accident? _____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

Have you ever had any previous episodes of this condition? _____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints No Yes **Explain:** _____

Nerves, Headaches, Dizziness, or Emotional No Yes **Explain:** _____

Head, Eyes, Ears, Nose or Throat No Yes **Explain:** _____

Heart, Blood Pressure, or Circulation No Yes **Explain:** _____

Shortness of Breath, Coughing, Asthma or Lung Condition No Yes **Explain:** _____

Stomach, Bowels or Digestive Conditions No Yes **Explain:** _____

Genital, Bladder, or Urinary Conditions No Yes **Explain:** _____

Diabetes, Thyroid or Glandular Conditions No Yes **Explain:** _____

Skin or Bleeding Conditions No Yes **Explain:** _____

Allergies or Sensitivities No Yes **Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? No Yes Explain: _____

Are there any past illnesses or conditions we should be aware of? No Yes Explain: _____

Do you have a past history of accidents or trauma? No Yes Explain: _____

Are there any past illnesses or conditions we should be aware of? No Yes Explain: _____

Are you presently taking any medication? No Yes Explain: _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? No Yes Explain: _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- Permanently fully disabled
- Permanently partially disabled
- Cannot work due to current condition
- Full-time (20-40+ hours/week)
- Part-time (1-19 hours/week)
- Retired Student Homemaker Unemployed

Personal social habits - Choose all that apply.

- Smoke or use tobacco products
- Drink alcohol
- Drink caffeine
- Use recreational drugs
- Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- No current exercises
- Exercises daily
- Exercises 3+ times per week
- Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- Vegan or vegetarian
- Daily supplements
- Other

MEN'S HEALTH

Do you have pain or lump in scrotum or testicles? Yes No

Do you have an impaired libido (sex drive)? Yes No

Do you have discharge from your penis? Yes No

Do you have prostate issues? Yes No

When was your last prostate exam? Within the past year Between 1-4 years
 Greater than 5 years Never had a prostate exam
 Prefers not to answer or don't know

When was your most recent PSA (Prostate-Specific Antigen) blood test? Within the past year Between 1-4 years
 Greater than 5 years Never had a PSA blood test
 Prefers not to answer or don't know

What was your PSA (Prostate-Specific Antigen) level on your latest test? Normal or low Moderate
 High Never had a PSA level done
 Prefers not to answer or don't know

WOMEN'S HEALTH

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control? Yes No

Do you experience painful periods? Yes No

Do you have irregular cycles? Yes No

Do you have breast implants? Yes No

Do you perform a regular self-breast examination? Yes No

Do you take hormone replacement therapy (HRT)? Yes No

Do you take oral contraceptives? Yes No

When was your last PAP/pelvic exam? Within the past year
 Between 1-4 years
 Greater than 5 years
 Never had a PAP or pelvic exam
 Prefers not to answer or don't know

Within the past year
 Between 1-4 years
 Greater than 5 years
 Never had a mammogram exam
 Prefers not to answer or don't know

What was the date of your last menstrual period? (only answer if still menstruating) Within the past month or currently
 Within the past 1-3 months
 Greater than 3 months
 Postmenopausal
 Have not yet begun menstruation
 Prefers not to answer or don't know

INFORMED CONSENT TO TREATMENT

I certify that I am the patient or legal guardian of the patient listed above.

I Instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and design to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

I have reviewed and been offered a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payors and to conduct normal health care operations such as quality assessments and accreditation.

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

FOR WOMEN OF CHILD BEARING YEARS: I realize that an X-ray examination may be hazardous to an unborn child and I will confirm the date of my last menstrual period with the doctor.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient Signature: _____ Date: ____ / ____ / _____
