

ABOUT YOU

First Name _____ Middle Name _____

Last Name _____

Street Address _____

Address Line 2 _____

City _____ State _____ Zip _____

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

Email Address _____

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 _____

INSURANCE INFORMATION

Do you have Insurance? Yes No

Insurance Name _____ Phone ____ - ____ - ____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip _____

ID/Policy # _____ Group # _____

Insured's Name _____ Insured's DOB ____ / ____ / ____

REFERRAL INFORMATION

Referring Physician _____ Contact Info _____

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?

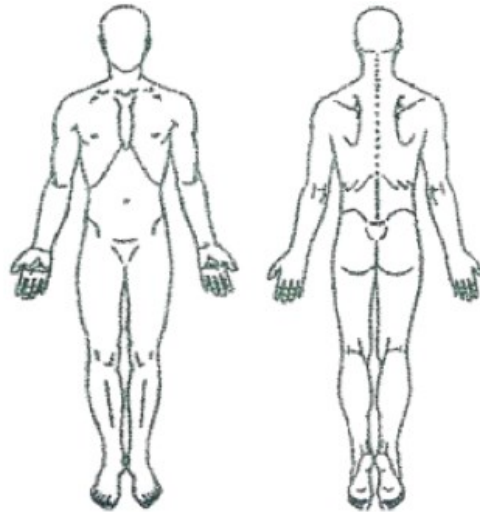
What is the date this condition began? (Skip if due to accident)

___ / ___ / _____

What terms describe your discomfort best? (aching, burning, tingling, etc.)

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 would you rate your current level of 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 have you received for this condition up to now?

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 AND SOCIAL HABITS

Current work habits: select 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: select all that apply

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

Present exercise habits: select all that apply

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

Diet and nutrition habits: select all that apply

- Vegan or vegetarian
- Daily supplements
- Other

ADULT MEN'S HEALTH

Do you have pain or a lump in your 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

ADULT 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? 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

When was your last mammogram? 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'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date: ____ / ____ / _____