## ABOUT YOU

**First Name** _____ **Middle Name** _____

**Last Name** _____

**Address Line 1** _____

**Address Line 2** _____

**City** _____ **State** _____ **ZIP Code** _____

**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** _____

## INSURANCE INFORMATION

**Do you have Insurance?** ☐ Yes ☐ No

**Insurance Name** _____ **Phone** ____-____-_____

**Address Line 1** _____

**Address Line 2** _____

**City** _____ **State** _____ **ZIP Code**_____

**ID/Policy Number** _____ **Group Number** _____

**Insured's Name** _____ **Insured's Date of Birth** ____ / ____ / _____

## 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)

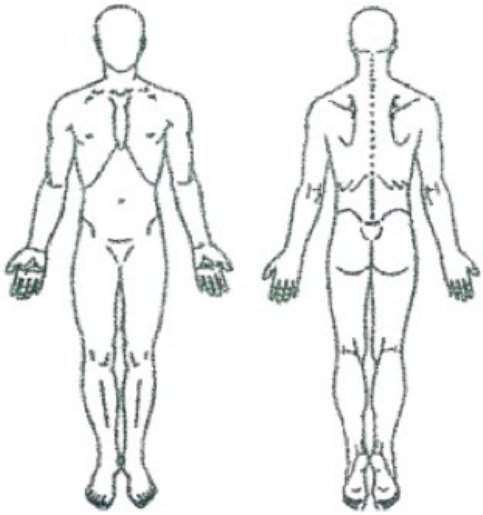
**What caused this condition** _____

**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* | | | | | | | | | | *Unbearable* |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**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 injury?** _____

_____

**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:** _____ |
| **Do you have any medication allergies?** | ☐ 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 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<br>☐ Greater than 5 years ☐ Never had a prostate exam<br>☐ 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<br>☐ Greater than 5 years ☐ Never had a PSA blood test<br>☐ Prefers not to answer or don't know |
| **What was your PSA (Prostate-Specific Antigen) level on your latest test?** | ☐ Normal or low ☐ Moderate<br>☐ High ☐ Never had a PSA level done<br>☐ 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<br>☐ Between 1-4 years<br>☐ Greater than 5 years<br>☐ Never had a PAP or pelvic exam<br>☐ Prefers not to answer or don't know |
| | ☐ Within the past year<br>☐ Between 1-4 years<br>☐ Greater than 5 years<br>☐ Never had a mammogram exam<br>☐ 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<br>☐ Within the past 1-3 months<br>☐ Greater than 3 months<br>☐ Postmenopausal<br>☐ Have not yet begun menstruation<br>☐ 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:** ____ / ____ / _____