

## 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)

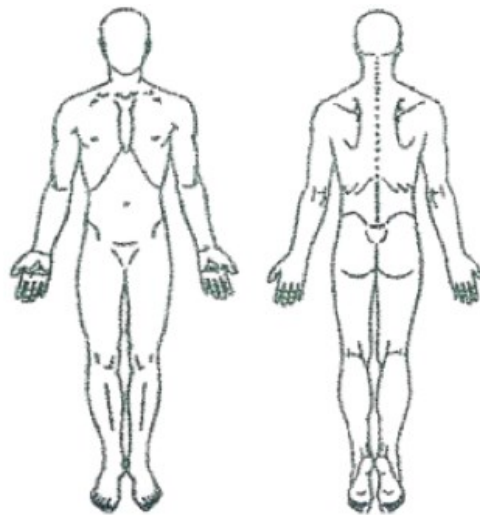
What caused this condition \_\_\_\_\_

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*      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 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  
☐ 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'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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_