WELCOME

Patient Information

Date:_____

Patient _____ **Age** _____ **Sex:** **M** ☐ **F** ☐

Address _____ **Apt.** _____ **Birthdate** _____

_____ **Patient SS#** _____

City State Zip **Cell #**_____

Home # _____ **Work #** _____ **Ext.** _____ **E-Mail** _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Best time & place to reach you** _____

IN CASE OF EMERGENCY, CONTACT: **Name** _____ **Relationship** _____

Home Phone _____ **Work Phone** _____ **Ext.** _____

Whom may we thank for referring you? _____

Work Information

Occupation _____ **Phone** _____ **Ext.** _____

Company _____ **Address** _____

Spouse Information

Name _____ **SS#** _____ **Birthdate** _____

Occupation _____ **Employer** _____

Insurance

Who is responsible for this account? _____ **Relationship to patient** _____

Insurance Co. _____ **Group #** _____

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**

Subscriber's name _____ **Birthdate** _____ **SS#** _____

Relationship to patient _____ **Insurance Co.** _____ **Group #** _____

AUTHORIZATION

I certify that I have read and understoodd the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

X _____ **Date** _____

Patient's Signature (or parent if a minor)

Current Patient Condition

Reason for visit _____

When did your symptoms appear? _____ **Is it getting progressively worse?** ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling Other_____

How often do you have this pain? _____ **Is it often or does it come and go?** _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Health History

Height _____ **Weight** _____ **Number of Children** _____

Are you recovering from a cold or flu? _____ **Are you pregnant?** _____

Reason for office visit: **Date started:**

_____ _____

_____ _____

_____ _____

Date of last physical exam _____ **Practitioner name & contact** _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis, saliva, bone density):

_____

Outcome _____

What types of therapy have you tried for this problem(s)?

☐ Diet modification ☐ Podiatrist ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic

☐ Acupuncture ☐ Conventional drugs ☐ Physical therapy ☐ Other _____

Medical: ☐ PCP/Internist ☐ Orthopedist ☐ Neurologist ☐ Neurosurgeon ☐ Psychiatrist

Date of exam _____ **Practitioner name & contact** _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

Current medications (prescription and/or over-the-counter): _____

_____

_____

Major hospitalizations, surgeries, injuries. Please list all procedures, complications (if any) and dates:

Year	**Surgery, illness, injury**	**Outcome**

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., job change, family status change, work related, finances, etc..) _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Just right **Your weight now:** _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? ☐ Yes ☐ No

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g, fireman, farmer, miner)?

_____

Do you experience any of these general symptoms EVERYDAY?

☐ Shortness of breath	☐ Nausea	☐ Fecal incontinence	☐ Bleeding	☐ Insomnia
☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge	☐ Constipation
☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash	☐ Chronic pain/inflammation

Medical History

- [ ] Arthritis
- [ ] Allergies/hay fever
- [ ] Asthma
- [ ] Alcoholism
- [ ] Alzheimer's disease
- [ ] Autoimmune disease
- [ ] Blood pressure problems
- [ ] Bronchitis
- [ ] Cancer
- [ ] Chronic fatigue syndrome
- [ ] Carpal tunnel syndrome
- [ ] Cholesterol - elevated
- [ ] Circulatory problems
- [ ] Colitis
- [ ] Dental problems
- [ ] Depression
- [ ] Diabetes
- [ ] Diverticular disease
- [ ] Drug addiction
- [ ] Eating disorder
- [ ] Epilepsy
- [ ] Emphysema
- [ ] Eyes, ears, nose, throat problems
- [ ] Environmental sensitivities
- [ ] Fibromyalgia
- [ ] Food intolerance
- [ ] Gastroesophageal reflux disease
- [ ] Genetic disorder
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart disease
- [ ] Inflammatory bowel disease
- [ ] Irritable bowel syndrome
- [ ] Kidney or bladder disease
- [ ] Learning disabilities
- [ ] Liver or gallbladder disease (stones)
- [ ] Mental illness
- [ ] Migraine headaches
- [ ] Neurological problems (Parkinson's, paralysis)
- [ ] Sinus problems
- [ ] Stroke
- [ ] Thyroid trouble
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Pneumonia
- [ ] Sexually transmitted disease
- [ ] Seasonal affective disorder
- [ ] Skin problems
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Urinary tract infection
- [ ] Varicose veins

Other _____

Medical (Men)

- [ ] Benign prostatic hyperplasia (BPH)
- [ ] Prostate cancer
- [ ] Decreased sex drive
- [ ] Infertility
- [ ] Sexually transmitted disease

Other _____

Medical (Women)

- [ ] Menstrual irregularities
- [ ] Endometriosis
- [ ] Infertility
- [ ] Fibrocystic breasts
- [ ] Fibroids/ovarian cysts
- [ ] Premenstrual syndrome (PMS)
- [ ] Breast cancer
- [ ] Pelvic inflammatory disease
- [ ] Vaginal infections
- [ ] Decreased sex drive
- [ ] Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam _____

Mammogram [ ] + [ ] -

PAP [ ] + [ ] -

Form of birth control _____

# of children _____

# of pregnancies _____

- [ ] C-section _____
- [ ] Surgical menopause
- [ ] Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval between cycles _____ days

Recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Healthy History

- [ ] Arthritis
- [ ] Asthma
- [ ] Alcoholism
- [ ] Alzheimer's disease
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Drug addiction
- [ ] Glaucoma
- [ ] Heart disease
- [ ] Infertility
- [ ] Learning disabilities
- [ ] Mental illness
- [ ] Mental retardation
- [ ] Migraine headaches
- [ ] Neurological disorders (Parkinson's, paralysis)
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Stroke
- [ ] Suicide

Other _____

_____

Health Habits

- [ ] Tobacco: # per day _____
- [ ] Alcohol:

Wine: # glasses/d or wk _____

Liquor: #oz./d or wk _____

Beer: # glasses/d or wk _____

- [ ] Caffeine:

Coffee: # 6oz. Cup/day _____

Tea: # 6oz. Cup/day _____

Soda: # cans/day _____

Other _____

- [ ] Water: # glasses/day _____

Exercise

- [ ] 5 - 7 days per week
- [ ] 3 - 4 days per week
- [ ] 1 - 2 days per week
- [ ] 45 min or more duration/wk
- [ ] 30 - 45 min duration/workout
- [ ] Less than 30 min
- [ ] Walk
- [ ] Run, Jog, jump rope
- [ ] Weight-lift
- [ ] Swim
- [ ] Box
- [ ] Yoga

Other _____

Nutrition & Diet

- [ ] Mixed food diet (animal & veg)
- [ ] Vegetarian
- [ ] Vegan
- [ ] Salt restriction
- [ ] Fat restriction
- [ ] Starch/carbohydrate restriction
- [ ] Total calorie restriction

Specific food restrictions: _____

_____

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- [ ] Skip breakfast
- [ ] One meal/day
- [ ] Two meals/day
- [ ] Three meals/day
- [ ] Graze (small frequent meals) (5 - 6 times/day)
- [ ] Food rotation
- [ ] Eat constantly (hungry or not)
- [ ] Eat on the run
- [ ] Add salt to food

Current Supplements

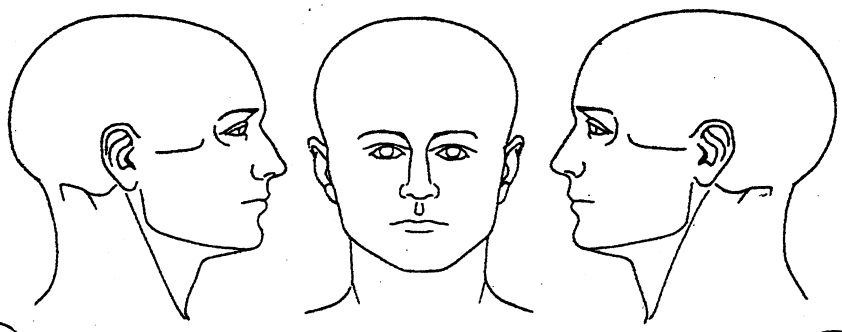
- [ ] Multivitamin/mineral
- [ ] Vitamin C
- [ ] Vitamin E
- [ ] EPA/DHA
- [ ] Evening primrose/GLA
- [ ] Calcium, source _____
- [ ] Magnesium
- [ ] Zinc
- [ ] Minerals, describe _____
- [ ] Friendly flora (acidophilus)
- [ ] Digestive enzymes
- [ ] Amino acids
- [ ] CoQ10
- [ ] Antioxidants (eg, lutein, resveratrol, etc.)
- [ ] Herbs - teas
- [ ] Herbs - extracts
- [ ] Chinese herbs
- [ ] Ayurvedic herbs
- [ ] Homeopathy
- [ ] Bach flowers
- [ ] Protein shakes
- [ ] Superfoods (eg. Phytonutrient blends)
- [ ] Liquid meals

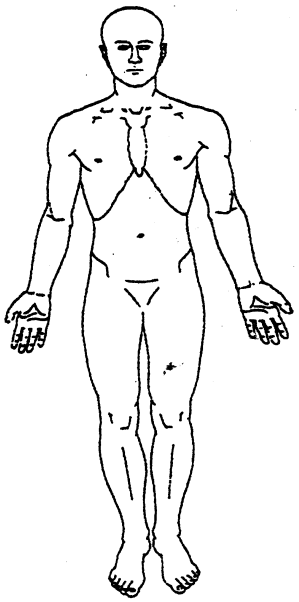
Other_____

Would you like to:

- [ ] Have more energy
- [ ] Be stronger
- [ ] Have more endurance
- [ ] Increase your sex drive
- [ ] Be thinner
- [ ] Be more muscular
- [ ] Improve your complexion
- [ ] Have stronger nails
- [ ] Have healthier hair
- [ ] Be less moody
- [ ] Be less depressed
- [ ] Feel more motivated
- [ ] Be more organized
- [ ] Think more clearly; be more focused
- [ ] Improve memory
- [ ] Do better on tests
- [ ] Not be dependent on over-the-counter meds like aspirin, ibuprofen, sleeping aids, etc
- [ ] Stop using laxatives or stool softeners
- [ ] Be free of pain
- [ ] Sleep better
- [ ] Have agreeable breath
- [ ] Have agreeable body odor
- [ ] Have stronger teeth
- [ ] Get less colds and flus
- [ ] Get rid of your allergies
- [ ] Reduce your risk of inherited disease tendencies (eg. cancer, heart disease, etc..)

CONFIDENTIAL PATIENT HISTORY

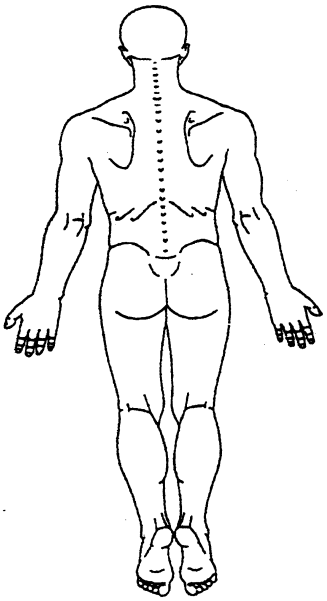




DRAW YOUR PATTERN OF PAIN

Draw the area of most intense pain darkest.

Draw the area of mildest pain lightest.



I verify that all information contained within these pages is true and accurate.

_____ _____

Patient's Signature Date