Today's Date: ____/____/_____

About You

Patient Name:_____ M / F (circle)
First MI Last

Birth date ____/____/_____ Age: _____

Address:_____
City State Zip

Home Phone:_____ Cell Phone:_____

Email Address: _____ Referred By: _____

Employer: _____ Occupation: _____

Marital Status: _____ SS# _____

Spouse's Name: _____ Spouse's Birth date: ____/____/_____

Other Doctor(s) seen and his/her specialty: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Is this your first visit to a Chiropractic Office?
☐ Yes ☐ No

Is your condition due to an accident injury?
☐ Yes ☐ No

If yes, did this occur:
☐ At work
☐ In an automobile
☐ During sports
☐ Other

Consent

I know that I am responsible for, and agree to pay all fees incurred at this office. I understand that any insurance benefits which I may have are a contracted arrangement between me and my insurance company. This office will be responsible for preparing notes, billing receipts and informational reports as needed to aid in insurance payment/reimbursement. I realize that this office is not responsible to negotiate disputed benefits for me.

I am choosing to be treated, for today and all my future visits at this office, through the use of various types of chiropractic manipulations, diagnostic x-rays and several types of physiologic modalities (physical therapy). I realize there is no guarantee of results, and have been informed that some risks of treatments do exist. These risks could include, but are not limited to: sprains, dislocations, fractures, strokes, and disc injury. While I do expect my doctor to use his/her best judgment to choose the most appropriate care for my condition, I agree that the doctor cannot foresee every possible complication or risk which could arise in my treatment.

My signature below signifies that I completely understand and agree to all of the above statements and give my consent for treatment.

_____ _____
Patient Signature Date

OVER→

Reason for today's visit: _____

When did your symptoms begin? _____

If there was a specific injury, please describe what happened: _____

_____

Since the problem started, it is: □ About the same □ Getting better □ Getting worse

Has your problem interfered with: □ Work □ Recreational activities □ Daily routine □ Sleep

I experience: □ Pain □ Bruising □ Numbness □ Tingling □ Weakness □ Cramping □ Stiffness □ Swelling

□ Loss bowel or bladder control □ Headaches □ Other _____

If you have pain, is it: □ Sharp □ Dull □ Stabbing □ Throbbing □ Aching □ Shooting □ Burning

On a scale from 0 (minimal) to 10 (severe), what is your pain TODAY? (circle) 0 1 2 3 4 5 6 7 8 9 10

On a scale from 0 (minimal) to 10 (severe), how severe can the pain get? (circle) 0 1 2 3 4 5 6 7 8 9 10

The problem is: □ Intermittent (comes and goes) □ Constant

Does the pain radiate/travel? □ Yes □ No If yes, where? _____

What makes your symptoms worse? □ Sitting □ Standing □ Bending □ Lying Down □ Walking □ Direct pressure

□ Coughing/Sneezing □ Lifting □ Kneeling □ Work Duties □ Specific movement: _____

What makes your symptoms better? □ Rest/not moving □ Sitting □ Lying Down □ Compression □ Heat □ Ice □ Medication

Exercise

□ None
□ Moderate
□ Daily
□ Heavy

Work Activity

□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits

□ Smoking…□ Quit…. Packs/Day _____
□ Alcohol……. Drinks/Week _____
□ Caffeine/Coffee…… Cups/Day _____
□ High Stress Level…. Reason _____

Health History

Please mark Y (Yes) or N (No) to indicate if you have had any of the following:

AIDS/HIV	□ Y □ N	**Eating Disorder**	□ Y □ N	**Migraines**	□ Y □ N	**STD's**	□ Y □ N
Alcoholism	□ Y □ N	**Emphysema**	□ Y □ N	**Miscarriage**	□ Y □ N	**Stroke**	□ Y □ N
Anemia	□ Y □ N	**Epilepsy**	□ Y □ N	**Mono**	□ Y □ N	**Suicide attempt**	□ Y □ N
Appendicitis	□ Y □ N	**Fractures**	□ Y □ N	**MS**	□ Y □ N	**Thyroid Problems**	□ Y □ N
Arthritis	□ Y □ N	**Glaucoma**	□ Y □ N	**Osteoporosis**	□ Y □ N	**Tonsillitis**	□ Y □ N
Asthma	□ Y □ N	**Goiter**	□ Y □ N	**Pacemaker**	□ Y □ N	**Tuberculosis**	□ Y □ N
Bleeding Disorder	□ Y □ N	**Gout**	□ Y □ N	**Parkinson's**	□ Y □ N	**Tumors**	□ Y □ N
Breast Lump	□ Y □ N	**Heart Disease**	□ Y □ N	**Pinched Nerve**	□ Y □ N	**Ulcers**	□ Y □ N
Bronchitis	□ Y □ N	**Hepatitis**	□ Y □ N	**Pneumonia**	□ Y □ N	**Vaginal Infections**	□ Y □ N
Cancer	□ Y □ N	**Hernia**	□ Y □ N	**Prostate Problems**	□ Y □ N	**Whooping Cough**	□ Y □ N
Cataracts	□ Y □ N	**Herniated Disc**	□ Y □ N	**Psychiatric Care**	□ Y □ N	**Other:** _____	
Chemical Dependency	□ Y □ N	**High BP**	□ Y □ N	**Rheumatoid Arthritis**	□ Y □ N	_____	
Chicken Pox	□ Y □ N	**High Cholesterol**	□ Y □ N				
Diabetes	□ Y □ N	**Kidney Disease**	□ Y □ N				
		Liver Disease	□ Y □ N				

Family History

List any major medical problems (diabetes, heart disease, cancer…) of your direct relatives:

Medications/Supplements/Vitamins

□ None _____

Allergies

□ None _____

Injuries/Surgeries

□ None _____

Are you interested in having your blood analyzed for nutritional deficiencies?

Current research has shown that nutritional (vitamin/mineral) imbalances can be a contributing factor in many patient conditions such as chronic fatigue, hypertension, asthma, blood sugar problems, arthritis, and many, many others.

We have in our office state of the art technology that can analyze your specific blood chemistry for vitamin/mineral imbalances and then identify which nutritional supplements you can take to address any imbalances.

☐ **Yes**, I am interested in having my blood analyzed for nutritional deficiencies so that I may know which vitamins/minerals I can take as an adjunct to traditional care.

☐ I'd like more information about having my blood chemistry analyzed for nutritional deficiencies before making a decision.

☐ **No**, I'm not interested. Please treat my condition with traditional care only.

If my insurance provider does not cover all of these expenses I would still be interested in having my blood analyzed for nutritional deficiencies so that I may know which specific vitamins/minerals are right for my body chemistry

☐ Yes ☐ No