PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. **(Please Print)**

Name _____ S/S ____-____-____ Date_____
Address _____ City_____ State_____ Zip _____
Sex (circle) Female Male Date of Birth ____/____/____
Home phone # (____) _____ Work # (____) _____ Email address: _____
I am: (circle one) a minor Married Divorced Widowed Single Separated
Your Employer _____ Occupation_____
Business Add_____ City _____ State _____ Zip _____
Spouse or Parent's name _____ Employer _____ Phone _____
Person to contact in case of emergency_____ Phone # (____) _____
Who referred you? _____

INSURANCE INFORMATION

Primary – *(present card to receptionist)*
Insurance _____ Primary Insured Name _____
Policy #/ SS# _____ Date of Birth ____/____/____
Secondary – *(present card to receptionist)*
Insurance _____ Primary Insured Name _____
Policy #/ SS# _____ Date of Birth ____/____/____

CHIROPRACTIC TREATMENT CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interests, based upon the facts as they are then known.

X_____ ____/____/____
Signature of Patient (or parent if a minor) **Date**

AUTHORIZATION/FINANCIAL RESPONSIBILITY

I authorize the chiropractor to release any information concerning my diagnosis and medical records about any treatment or examination rendered to me or my child during the period of chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the chiropractor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that payment for services and/or the applicable copayment is due at the time of service.

X_____ ____/____/____
Signature of Patient (or parent if a minor) **Date**

CURRENT CONDITION

What are your objectives in visiting the chiropractor?

_____

_____

_____

If you are here due to pain, please describe what you were doing when the pain first occurred.

_____

_____

Describe what your pain feels like.

_____

_____

What do you do to relieve the pain? _____

Please list any major accidents, falls or injuries within the approximate date.

_____

_____

_____

How do the following activities change your pain and what duration of time can you tolerate each activity?

	No Change	Relieves	Increased	Duration
Sitting	[ ]	[ ]	[ ]	_____
Looking up	[ ]	[ ]	[ ]	_____
Walking	[ ]	[ ]	[ ]	_____
Looking Down	[ ]	[ ]	[ ]	_____
Standing	[ ]	[ ]	[ ]	_____
Turning	[ ]	[ ]	[ ]	_____
Lying Down	[ ]	[ ]	[ ]	_____
Bending	[ ]	[ ]	[ ]	_____
Lifting	[ ]	[ ]	[ ]	_____

On a scale of 1-10, rate the severity of your pain. If your pain fluctuates please mark both and indicate approximately the % of time at each level Example 0 1 2 3 4 5 6 7 8 9 10 (70% / 30%)

	No Pain									Severe Pain
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

If you have ever visited a chiropractor or chiropractors in the past, please list:

_____

What did you like or not like about your previous treatment experiences?

_____

SUMMARY

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes. when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
   _____
6. Describe the pain: Sharp ____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? *Standing* ____ *Sitting* _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS _____ EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

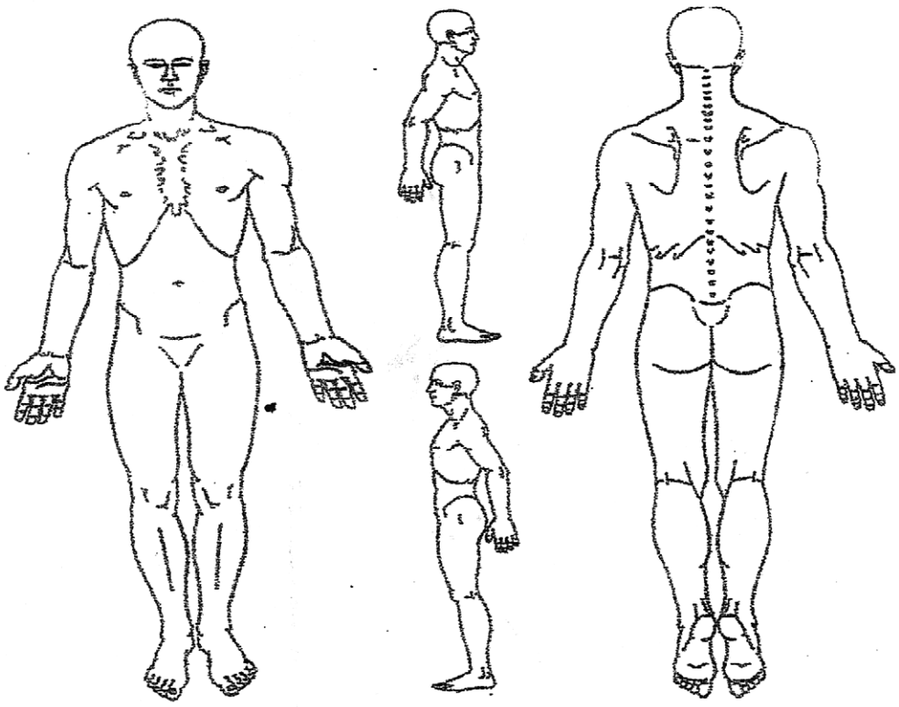
Name of primary care doctor_____
Address_____
Phone Number_____

Doctor's Signature_____ Date:_____

Mark the areas on this body where you feel pain. Use the appropriate symbols.

KEY:
USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE	**B = BURNING**	**C = STABBING**
N = NUMBING	**P = PINS & NEEDLES**	**O = OTHER**



Please give approximate date of last:

Spinal Exam _____ Physical Exam _____

Spinal X-Ray _____ Other Spinal Imaging _____

Please UNDERLINE all of the following conditions you have had PREVIOUSLY.
CIRCLE all of the following conditions you have NOW.

GENERAL
Headache
Fainting
Diabetes
Cancer
Fainting
Epilepsy
Dizziness
Convulsions
Weight loss
Weight gain
Allergy

E.E.N.T.
Failing vision
Near sighted
Far sighted
Crossed eyes
Deafness
Earache

RESPIRATORY
Chronic cough
Pneumonia
Pleurisy
Asthma

SKIN
Skin eruptions
Varicose veins
Sensitive skin
Hives
Eczema

CARDIO-VASCULAR
Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Previous heart stroke
Hardening of arteries
Swelling of ankles

MUSCLE/JOINT
Head injury
Spinal injury
Tail bone injury
Shoulder / elbow
Wrist / hand
Hip / knee
Ankle / foot
Spinal / curvature
Faulty posture
Arthritis
Polio
Gout
Swollen joints
Hernia
Chronic fatigue
Fibromyalgia

GENITOURINARY
Frequent urination
Painful urination
Kidney infection/stone
Bed wetting
Inability to control urine
Prostate trouble

GASTROINTESTINAL
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Stomach pain
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis
Irritable bowel

FOR WOMEN ONLY
Painful menstrual periods
Excessive flow
Hot flashes
Cramps or backache
Previous miscarriage
Lumps in breast
Menopausal symptoms
Are you pregnant?
Yes____ No _____

Height _____

Respiration_____

Weight_____

Blood Pressure _____

Pulse _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

_____ **Patient's Signature** _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____