

Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About this Patient

First Name

Last Name

Cell Phone

Birthday

Marital Status

Gender

Married

Single

Female

Male

Email

Social Security #

Street Address

City

State/Province

Zip Code

About the Spouse

First Name

Last Name

Spouse's Cell Phone

Employer Information

Employer

Work Address

Work City

Work State

Work Zip

Work Phone

Type of Work

Reason for this Visit

Is the purpose of this appointment related to:

- Job Sports Auto
 Fall Chronic Discomfort Home Injury
 Other

If job related, have you made a report of your accident to your employer?

- Yes No

Please explain.

When did this condition begin?

Has this condition

- Gotten worse Stayed Constant
 Comes and goes

Has this condition occurred before?

- Yes No

Does this condition interfere with

- Work Sleep
 Daily Routine Other activities

Explain

Have you seen other doctors for this condition?

- No Yes

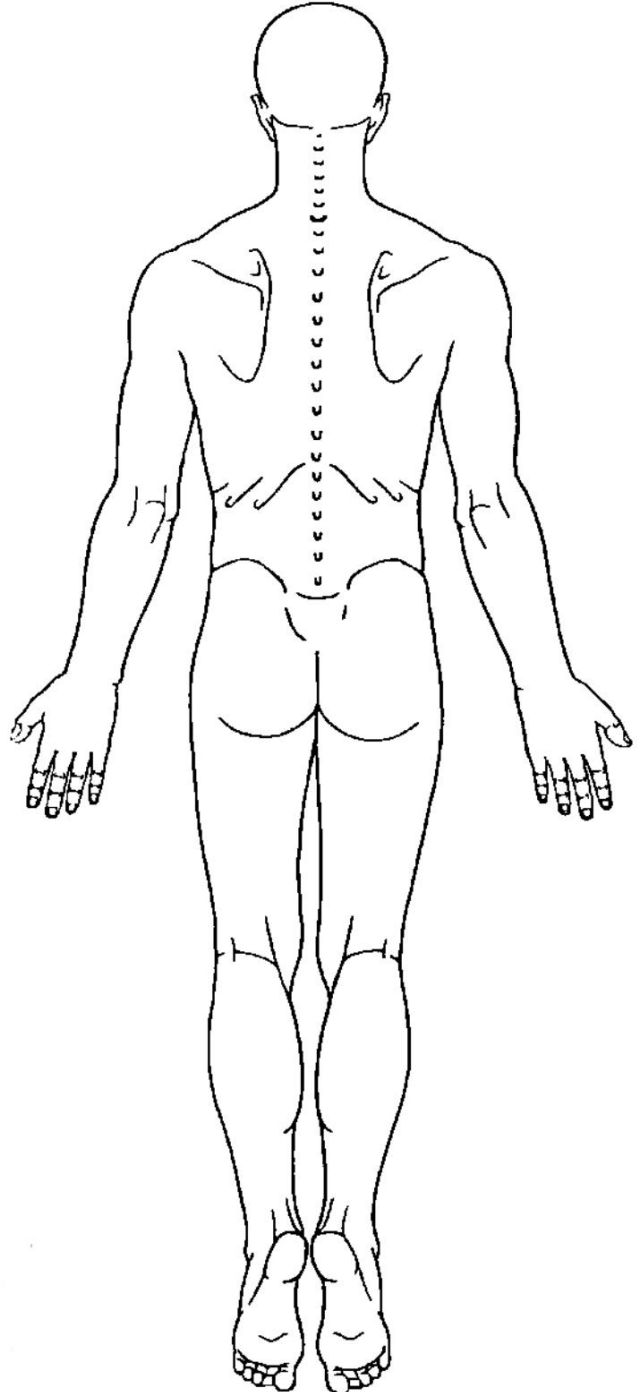
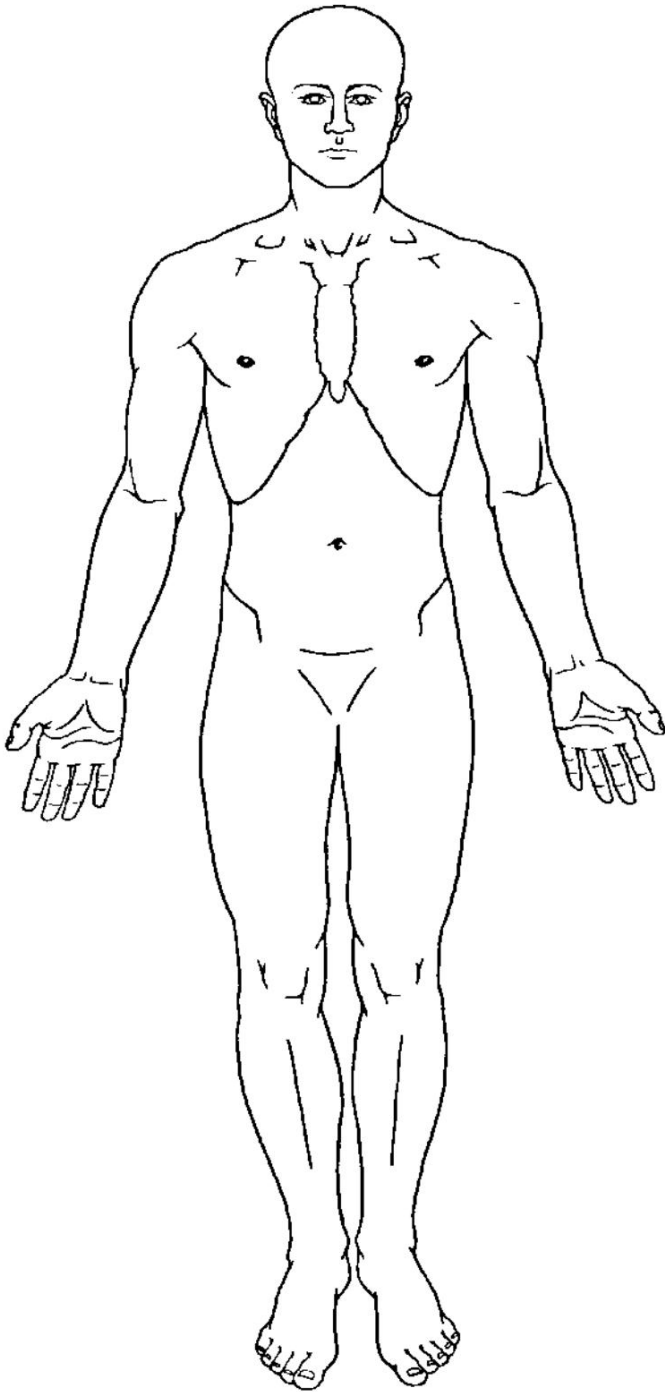
Doctor's Name (s)

Type of Treatment

Results

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Experience with Chiropractic

Have you been adjusted by a chiropractor before?

- Yes No

Has any adult in your family seen a Chiropractor?

- Yes No

Has any child in your family seen a Chiropractor?

- Yes No

Doctor's Name

Approximate date of last visit?

Reason for those visits?

Awareness of Chiropractic Principles

Were you aware that...

Doctors of Chiropractic work with the nervous system?

Yes No

The nervous system controls all bodily functions and systems?

Yes No

Chiropractic is the largest natural healing profession in the world?

Yes No

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

Yes No

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort

Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

Yes

Health Habits & Conditions

Medications I Now Take:

Nerve Pills
 Blood Pressure Medicine
 Blood Thinners

Pain Killers (including Aspirins)
 Insulin
 Tranquilizers

Muscle Relaxers
 Stimulants

Do you smoke?

Yes No

Do you drink alcohol?

Yes No

Do you drink coffee?

Yes No

Do you exercise regularly?

Daily Moderately No

Do you wear:

Heel lifts Sole Lifts
 Inner Soles Arch Supports

Health Conditions:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> Frequent Neck Pain |
| <input type="checkbox"/> Numbness in Arms/Legs/Hands | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Anemia | |

Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Sitting to Standing

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Climb Stairs

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Driving

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Extended Computer Use

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Getting Dressed

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Lifting Children/Groceries

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Sexual Activities

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Sleep

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Static Sitting

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Static Standing

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Walking

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Washing/Bathing

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
|------------------------------------|---|---|--|

Yard Work No Effect Painful (can do) Painful (limits) Unable to Perform**FOR WOMEN ONLY:****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**Authorization for Care**

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Patient's Signature**Date**

Guardian or Spouse's Signature**Date**

Who should receive bills for payment on your account? Patient Spouse Parent Workers Comp Medicare Personal Health Insurance Auto Insurance**Ownership of X-ray Films**

It is understood and agreed that the payments to the Doctor for X-rays is for the examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Emergency Contact**First Name****Last Name**

Relationship

Work Phone**Home Phone**

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself . I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company

Policy #

Group #

Address

Phone Number

ABOUT THE INSURED PERSON

First Name

Last Name

Social Security #

Date of Birth

Relation

Nutrition and self-care are just two of the components in obtaining optimal wellness.

Please let us know what you are currently doing for your health.

Things I do currently to support my health include:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Drink plenty of water | <input type="checkbox"/> Exercise regularly | <input type="checkbox"/> Get plenty of rest | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Pray/Meditate | <input type="checkbox"/> Yoga/Pilates/Aerobics | <input type="checkbox"/> Alcohol in moderation | <input type="checkbox"/> Homeopathic remedies |
| <input type="checkbox"/> Maintain positive attitude | <input type="checkbox"/> Self-improvement books | <input type="checkbox"/> Eat organically grown foods | <input type="checkbox"/> Vitamins, minerals or herbs |
| <input type="checkbox"/> Maintain the proper weight | <input type="checkbox"/> Receive regular massages | <input type="checkbox"/> Counseling/Therapy | <input type="checkbox"/> Orthotics/Heel Lefts |
| <input type="checkbox"/> Use a cervical pillow | <input type="checkbox"/> Attend religious services | <input type="checkbox"/> Annual physical examinations | |

Please indicate which of these you do/have on a consistent basis:

- | | |
|--|---|
| <input type="checkbox"/> Eat fast food | <input type="checkbox"/> Work long hours |
| <input type="checkbox"/> Feel overwhelmed/Exhausted/Fatigued | <input type="checkbox"/> Experience gas/Bloating/Indigestion |
| <input type="checkbox"/> Experience food sensitivities/Allergies | <input type="checkbox"/> Periods of constipation/Loose stools/Irregularities |
| <input type="checkbox"/> History of pinched nerve/Slipped or herniated disc/Joint degeneration | <input type="checkbox"/> Popping/Crackling/Stiffness in your joints |
| <input type="checkbox"/> Family diagnosed with Osteoporosis/Thin brittle bones | <input type="checkbox"/> Muscle cramps (sports or menstrual) |
| <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Weak or thin/Hair/Nails/Skin |
| <input type="checkbox"/> Tooth decay | <input type="checkbox"/> Family history of heart disease |
| <input type="checkbox"/> Low energy/Loss of vitality | <input type="checkbox"/> Family history of colds/Flus/Infections/Poor immune system |
| <input type="checkbox"/> Poor gum health/Gingivitis | <input type="checkbox"/> Cravings for sugary foods |
| <input type="checkbox"/> Struggle with weight loss | <input type="checkbox"/> Lack of protein in diet |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Struggle with eating healthy throughout the day |
| <input type="checkbox"/> Currently taking vitamin supplements | |

Please list any vitamin supplements you are currently taking

Initial Consultation Form

Primary Complaint (s):

Overall frequency of complaint (choose one)

- Constant - 100% of the time Frequent - 75% Intermittent - 50% Occasional - 25%

Overall intensity of complaint (choose one)

- Minimal (An annoyance but has no effect on activity) Slight (Tolerable with some impairment to activity)
 Moderate (Tolerable with marked impairment of activity) Severe (Intolerable and cannot perform any activities)

Is this problem affecting any other area of your body? If yes, please explain:

Does it interfere with your normal daily activities (Family, recreation, sports)?

Does your symptoms increase while performing your normal work duties?

- Yes No

If yes, please select the amount below that you feel your symptoms increase at work:

- 0% 10% 20% 30%
 40% 50% 60% 70%
 80% 90% 100%

What aggravates the problem?

What relieves the problem?

If this problem went without being taken care of, how do you think it would affect you?

Patient's Signature

Date

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week.
- In the instance of a no show without notice by phone we reserve the right to charge you a \$25.00 fee.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Patient's Signature

Date

Today's payment will be made by:

Cash

Check

Credit Card

Insurance:

We will verify all insurances and your benefits per your agreement with your carrier. After verification the Doctor will give his recommendations and an appropriate plan will be designed for each individual. Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Signature

Date Signed

Printed Name

Email
