CHIROPRACTIC

Bringing Out The Best In You

Patient _____

Doctor _____

Date _____ Case # _____

○ New Patient

Welcome To Our Office

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Is it okay to contact you at work? ○ no ○ yes Work # _____

E-mail address _____ Web site _____

SS# _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Marital status ○ single ○ married ○ separated ○ divorced ○ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

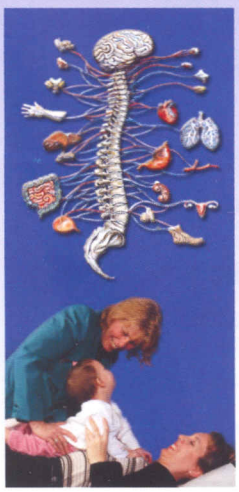
Do you have any pets? ○ no ○ yes If yes, please tell us what kind(s) _____

_____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

Favorite hobbies or interests _____



What Brings You Here?

Have you ever had chiropractic care before? ○ no ○ yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? ○ no ○ yes

How did you find out about our office? _____

Is this appointment related to ○ work ○ sports ○ auto
○ personal injury ○ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? ○ no ○ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ○ no ○ yes If yes, what month? _____

This form continues. Please turn the page.

Current Health

What are your most pressing health concerns? _____

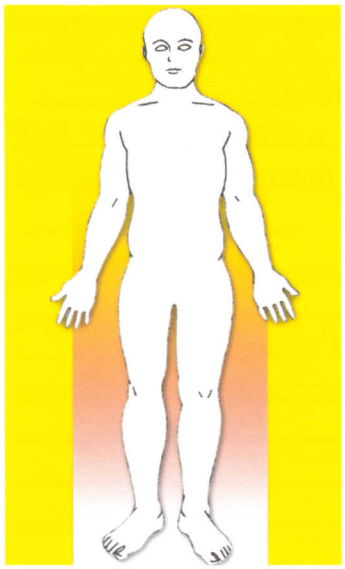
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent
❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

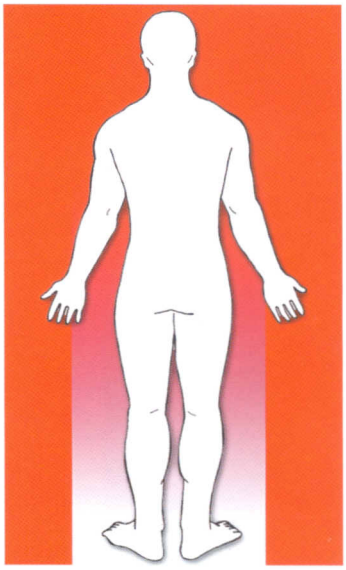
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking ❍ bending ❍ lying down ❍ weather

Please explain _____

Do you feel ❍ cramps ❍ burning ❍ other _____
❍ swelling ❍ stiffness

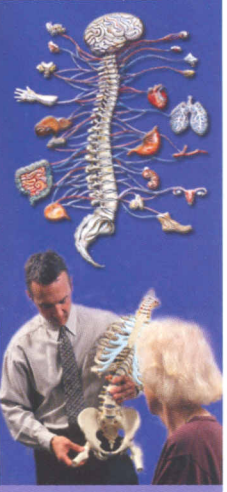
Do your symptoms interfere with ❍ work ❍ sleep ❍ other _____
❍ day-to-day activities ❍ play

Please explain _____

_____

On a scale of 1-10 *(1 least, 10 most)*, please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10



Health History

Do you have, or have you had, any of the following (*please check ☑ all that apply*)

- ❍ pneumonia
- ❍ pleurisy
- ❍ epilepsy
- ❍ eczema
- ❍ mumps
- ❍ polio
- ❍ cancer
- ❍ measles
- ❍ influenza
- ❍ chickenpox
- ❍ depression
- ❍ arthritis
- ❍ rheumatic fever
- ❍ thyroid disease
- ❍ whooping cough
- ❍ heart disease
- ❍ smallpox
- ❍ diabetes
- ❍ anemia
- ❍ rashes

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you use

- ❍ coffee
- ❍ alcohol
- ❍ tea
- ❍ cigarettes
- ❍ artificial sweeteners
- ❍ recreational drugs
- ❍ sugar

Have you ever suffered from (*please check ☑ all that apply*)

- ❍ neck pain
- ❍ low back pain
- ❍ headache
- ❍ migraines
- ❍ arm back/tingling
- ❍ shoulder pain
- ❍ hand pain/tingling
- ❍ leg pain/tingling
- ❍ jaw pain
- ❍ chest pain
- ❍ lung problems
- ❍ heart problems
- ❍ abnormal blood pressure
- ❍ irregular heartbeat
- ❍ ankle swelling
- ❍ cold extremities
- ❍ blurred vision
- ❍ vision problems
- ❍ difficulty breathing
- ❍ stuffy nose
- ❍ allergies
- ❍ fainting
- ❍ weight loss
- ❍ poor appetite
- ❍ excessive appetite
- ❍ nervousness
- ❍ confusion
- ❍ depression
- ❍ dental problems
- ❍ excessive thirst
- ❍ frequent nausea
- ❍ vomiting
- ❍ prostate problem
- ❍ breast pain/lump
- ❍ cramps
- ❍ painful urination
- ❍ bladder trouble
- ❍ excessive urination
- ❍ discolored urine
- ❍ gas/bloating after meals
- ❍ heartburn
- ❍ colitis
- ❍ irritable bowel
- ❍ black or bloody stools
- ❍ constipation
- ❍ hemorrhoids
- ❍ liver problems
- ❍ stroke
- ❍ paralysis
- ❍ tingling
- ❍ numbness
- ❍ fatigue
- ❍ dizziness
- ❍ loss of sleep
- ❍ difficulty hearing
- ❍ ear pain

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check ☑ all that apply*)

- ❍ falls/accidents
- ❍ sports injuries
- ❍ spinal tap
- ❍ use(d) a cane or walker
- ❍ knocked unconscious
- ❍ head injuries
- ❍ broken bones
- ❍ surgery
- ❍ extensive dental work
- ❍ fights
- ❍ dislocations
- ❍ traction
- ❍ dental appliances

If yes to any of the above, please describe _____

_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

_____

Do any friends or relatives see chiropractors? ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you?

❍ no ❍ yes If yes, please tell us. _____

_____

_____

_____

Notes _____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care?

❍ Cash ❍ Check ❍ Credit Card # _____ Exp. _____

Insurance co. _____ Group Policy # _____

Address _____ Phone # _____

Insured's name _____

Relation _____ Insured's employer _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)