The Practice of

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PATIENT_INFORMATION

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

Name _____ Date_____ Date of Birth _____ Age _____ ☐Female ☐Male

Address _____City _____ State _____Zip _____ Home phone _____

Work phone _____ Your employer _____Occupation_____

Business Address_____ City _____State _____Zip _____

Are you: ☐Minor ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated Do you have children?_____

Spouse or Parent's name _____ Person to contact in case of emergency_____

Emergency contact Phone # _____Whom may we thank for referring you to us? _____

Email address (office newsletters):_____ Date your symptoms began _____

INFORMED 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. The most common side-effects are of short duration and include local discomfort in the area of treatment, pain, and headache. The scientific literature suggests that serious events such as stroke are rare and that chiropractic is safe.

AUTHORIZATION

I certify that I have read and understand 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 agree to be responsible for payment of all services rendered to me or my dependents.

X_____ ____/__/____

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

FINANCIAL RESPONSIBILITY

Payment for services are due at the time services are rendered unless other arrangements have been approved in advance. Our fees normally fall within the UCR which is defined as the usual, customary, and reasonable charges for this region. This office has no contract with any insurance agency, only with you, the patient. You may submit your receipt to your insurance provider for reimbursement if you are eligible. Not all insurance providers will pay for services performed at this office as it is considered a non-participating provider. It is your responsibility to determine if you are eligible for reimbursement.

I fully understand this agreement between this office and myself. I am ultimately responsible for the balance of my account for any professional services rendered.

X_____ ___/___/___

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

A. Complaints/Concerns

1. **Please list your main health objectives or chief complaints.**

_____

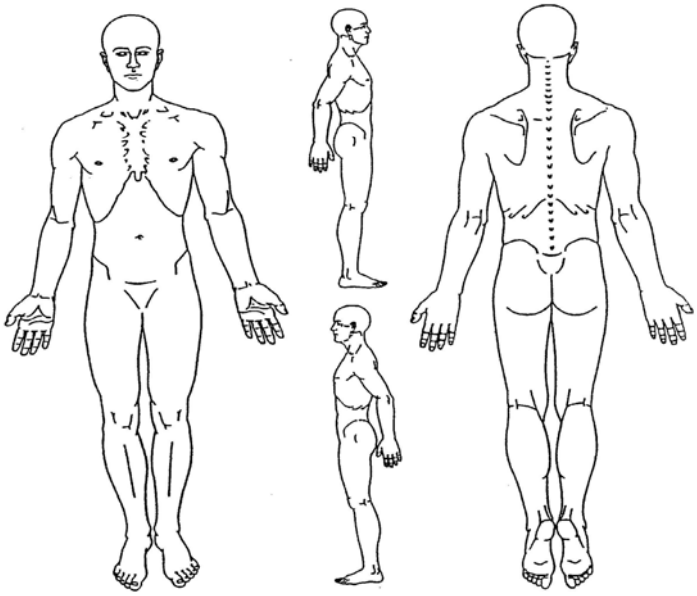
When did you first notice this?_____Describe what the condition feels like_____
What do you do for relief? _____

2. **On a scale of 0- 10 rate the severity of your pain today.** If your pain fluctuates please indicate approximately the % of time at each pain level. *Example* 0 1 2 ③ 4 5 6 7 ⑧ 9 10

70% 30%

	No Pain										Worst Pain Possible
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
Headaches	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

3. **Indicate on the diagram where you have your complaints. Check the appropriate descriptions of the complaints in the box to the right of the diagram**.



The sensations I feel are:
Pain ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Soreness ☐ Swelling ☐

The quality of the pain is:
Burning ☐ Dull ☐ Sharp ☐ Shooting ☐ Aching ☐ Throbbing ☐

The pain duration is:
Occasional ☐ Intermittent ☐ Frequent ☐ Constant ☐

My condition is:
Improving ☐ Worsening ☐ Unchanged ☐ Resolved ☐

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

	No Change	Relieves	Increased	Duration		No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____	Looking up	☐	☐	☐	_____
Walking	☐	☐	☐	_____	Looking down	☐	☐	☐	_____
Standing	☐	☐	☐	_____	Turning	☐	☐	☐	_____
Lying Down	☐	☐	☐	_____	Bending	☐	☐	☐	_____
Lifting	☐	☐	☐	_____	Pull/Pushing	☐	☐	☐	_____
Reaching	☐	☐	☐	_____					

5. **How did your complaint(s) begin?**
☐Unknown ☐Suddenly ☐Gradually

6. **When are your symptoms worse?**
☐Morning ☐Afternoon ☐Evening ☐Night
☐Always the same

7. **What happened to cause or re-aggravate your complaint(s)?**
☐Cause Not Known ☐Auto Accident
☐Work Accident/Injury ☐Home Accident
☐Personal Injury ☐Sport Injury
☐Other – Describe: _____
_____

8. **Since your symptoms began, have you noticed a change in?**

Bowel Function	☐Yes	☐No
Bladder Function	☐Yes	☐No
Sexual Function	☐Yes	☐No
Muscular Strength	☐Yes	☐No
Coordination	☐Yes	☐No

9. **Please check if these activities worsen your symptoms.**
☐Laughing ☐Coughing ☐Straining at Stool

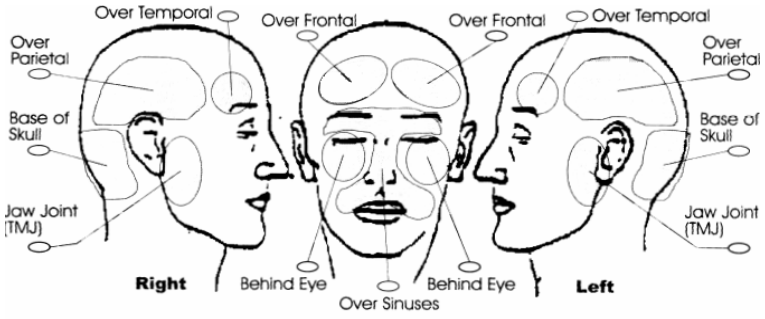
10. **What makes your condition better?**
☐Nothing ☐Rest ☐Sitting ☐Stretching
☐Exercise ☐Standing ☐Medications ☐Ice
☐Heat
☐Other _____

11. **Have any of your complaints existed in the past?** ☐Yes ☐No
If yes, indicate below
☐Neck ☐Uppr back ☐Mid Back ☐Low Back
☐Shoulder ☐Arm ☐Elbow ☐Forearm
☐Wrist ☐Hand/Finger ☐Buttock ☐Hip
☐Thigh ☐Knee ☐Leg/Calf ☐Ankle
☐Foot ☐Others:

12. **Have you had any recent treatment for your conditions OUTSIDE of this office?**
☐Yes ☐No If yes, List Dates, Treatments, and Doctors
_____
_____
_____

B. HEADACHES – If you have headaches fill out this section, otherwise skip to Section C.

1. **Where is the pain associated with your headaches?**



2. **On what date did your headaches begin?**
Date: ___/___/___ ☐Same as Neck/Back complaints

3. **What describes your pain?**
☐Dull ☐Sharp ☐Deep ☐Burning
☐Aching ☐Stabbing ☐Vice-Like ☐Throbbing/Stabbing
☐Other:

4. **When do your headaches usually start?**
☐Constant/Anytime Awake ☐Wake up with in morning
☐At mid-day ☐During evening

5. **Do your headaches wake you from sleep?**
☐ No ☐Sometimes ☐Always

6. **What seems to bring on your headaches?**
☐Physical Activity ☐Caffeine ☐Excess stress
☐Certain Foods ☐Alcohol ☐Menstruation
☐Other:

7. **How often do your headaches occur?**
☐Times/Week: ⓪①②③④⑤⑥⑦⑧⑨⑩
☐Times/Month: ⓪①②③④⑤⑥⑦⑧⑨⑩
Other: _____

8. **How long do your headaches last?**
☐Less than 1 hour ☐From 1-3 hours
☐Longer than 3 hours ☐All waking hours
☐Several hours to days ☐Other

9. **Do any of the following occur with your headaches?**
☐Nausea/Vomiting ☐Weakness
☐Tremor ☐Vision Problems
☐Dizziness ☐Light/Sound Sensitivity
☐Other

10. **What makes your headaches better?**
☐Nothing ☐Rest
☐Lying down ☐Ice/cold packs
☐Massage ☐Standing
☐Over the counter medications
☐Other

C. REVIEW OF SYSTEMS

Please underline all of the following conditions you had previously. Please circle all of the following conditions you have now.

GENERAL
General Fatigue
Weakness
Fever
Chills
Weight Change
Night Sweats
Anemia
Bleeding Tendency
Diabetes
Cancer
Thyroid Problems
Allergies
Frequent Illness
Autoimmune Disease

SKIN
Skin Rash
Redness of Skin
Skin Itching
Skin Dryness
Eczema
Hair Changes
Nail Changes
Bruise Easily

EENT
Hearing Trouble
Ringing in Ears
Pain in Ears
Ear Discharge
Vision Trouble
Pain in Eyes
Eye Discharge
Glaucoma
Cataracts
Use glasses/contacts
Nose/Sinus pain
Excessive Drainage
Nose bleeds (chronic)
Nasal Infections
Absence of Smell
Mouth Sores
Bleeding Gums
Enlarged Glands
Absence of Taste
Tonsillitis
Difficulty Swallowing

HEART/CHEST
Chest pain
Cough
Wheezing
Difficult Breathing
Swollen Limbs
Blue Skin
Varicose Veins
Rapid Heart Beat
Heart Palpitations
Heart Murmurs
High Blood Pressure
Tuberculosis
Asthma
Bronchitis
Heart Attack
Other Heart Disorder
Pneumonia

URINARY
Painful urination
Frequent urination
Urgency
Incontinence
Blood in Urine
Kidney Stones
Bed-wetting
Urine odor

GI SYSTEM
Decreased Appetite
Increased Appetite
Abdominal Pain
Hemorrhoids
Excess Gas
Diarrhea (excess)
Constipation (excess)
Heartburn
Irritable Bowel
Vomiting
Excessive Thirst
Rectal Bleeding
Hepatitis
Liver Disease
Gallbladder Disease
Black tarry stools

MALES
Prostate problems
Hernias
Impotence
Pain

FEMALES
Menstrual Pain
Irregular Periods
Itching
Discharge
Hernias
Hot Flashes
Hormone Replace

MALE/FEMALE
Breast Lumps
Redness of breasts
Breast Pain

NEUROLOGIC
Dizziness
Headaches
Fainting
Head Injury
Convulsions
Nervousness
Stroke
Paralysis
Tremors
Memory Loss
Disorientation
Anxiety
Depression
Phobias
Mood Swings

MUSCLE/BONE
Poor Posture
Spine Injury
Scoliosis
Arthritis
Polio
Gout
Fibromyalgia
Muscle Cramps
Joint Pain
Joint Stiffness

D. HABITS/ACTIVITIES

What are your current habits?

Packs Per Day
Smoking ☐Never ☐<1 ☐1-2 ☐>2

Glasses Per Day
Caffeine ☐Never ☐<1 ☐1-2 ☐>2

Glasses Per Day
Alcohol ☐Never ☐<1 ☐1-2 ☐>2

Drug Abuse ☐No ☐Yes

Days Per Week
Exercise ☐Never ☐<1 ☐1-3 ☐>3
Kinds of Exercise You Do:
☐Walking ☐Jogging ☐Cycling ☐Golf
☐Tennis ☐Strength Training ☐Swim
☐Other:

E. HEALTH HISTORY

1. **Have you ever been to a chiropractor?**
   ☐Yes ☐No

2. **Family Physician Information**
   Date of Last Exam _____
   Physician's Name _____
   Location _____

3. **Have you ever been hospitalized?**
   ☐Yes ☐No
   Date and reason for hospitalization:_____
   _____

4. **Have you ever had surgery?**
   ☐Yes ☐No
   Date, surgery and results:_____
   _____

5. **Have you ever had a serious injury?**
   ☐Yes ☐No
   List Date & Describe Injury:

☐Auto_____
☐Work-related _____
☐Personal _____
☐Sports Injury _____
☐Other _____

6. **Are you currently taking any vitamins, minerals, or herbs? (List)**
   _____
   _____

E. HEALTH HISTORY - CONTINUED

7. **Are you currently taking any medications?** □Yes □No
For what condition(s) are you taking medication?
□Anti-Inflammatory (Aspirin, Ibuprofen, etc.)_____
_____
□Pain/Analgesics _____
□Anti-Depressants _____
□Muscle Relaxers _____
□Blood Pressure Pills _____
□Antibiotics _____
□Birth Control Pills _____
□Corticosteroid _____
□Other: _____

Have you **ever** used the following?
□Birth Control Pills □Corticosteroids

Are you allergic to seafood or sulfa drugs? □Yes □No

8. **Women Only**
To your knowledge, are you pregnant?
□Yes □No
If pregnant in the past were pregnancies normal?
□Yes □No
Are you seeing an OB-GYN regularly?
□Yes □No

9. **Emotional Health**
How would you rate your current emotional health from 0-10?

Worst Possible Best Possible
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

10. **Have you ever had a fractured bone?** □Yes □No
Please list: _____
_____

11. **Please give date of last:**
X-ray _____ Other Imaging _____

F. FAMILY HISTORY

	Cancer	Stroke	Diabetes	Heart Attack	Autoimmune
Grandparent	□	□	□	□	□
Father	□	□	□	□	□
Mother	□	□	□	□	□
Sibling	□	□	□	□	□

Other: _____

G. OCCUPATIONAL/DAILY ACTIVITIES

1. **Are you right or left handed?** □Right □Left

2. **In what position do you sleep**?
□Back □Side □Stomach

3. **Job Type**

□Retired □Unemployed □Full-time Student
If Any of Above Skip Rest, Sign at Patient's Signature

□Full Time □Part Time □Temporary
□Self-Employed

4. **During your work week, you work how many:**
Hours /Day ⓪①②③④⑤⑥⑦⑧⑨⑩
Days/Week ⓪①②③④⑤⑥⑦⑧⑨⑩

5. **How long have you worked in this job?**
_____

6. **Do your present complaints affect the number of hours worked each day?** □Yes □No

7. **What is your primary work position?**
□Seated □Standing □Other

8. **What movements does your job require?**
□Bending □Turning □Stooping
□Twisting □Walking □Repetitive Actions
□Carrying Other:

9. **Does your work include?**
□Prolonged computer use □Continuous Phone Use

10. **Does your job involve lifting?**
□Never □Occasional □Frequent
□Constant
How many pounds: _____

11. **What is your stress level at work?**
□Minimal □Moderate □Extreme

11. **Rate your physical activity at work:**
□Seated more than 50% of the day

Manual Labor: □Light □Moderate □Heavy

12. **Do work activities aggravate your complaints?**
□Yes □No If yes, how? _____

PATIENT'S SIGNATURE **DATE**

_____ _____