DATE

Personal History

Legal First and Last Name: ____________________________Preferred or Called Name:_____________

Address:_______________________________ City:_______________ State:_____ Zip:________

Birth Date:____________________ Age:_______ Sex: ☐ M ☐ F

Home Phone:_____________ Cell Phone:_____________ Work Phone: _____________________

E-mail Address:__________________ SSN: _____________ Driver's License #:__________________

Check One: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner ☐Engaged

Name and Ages of Children (if applies):____

Employer:____________________________ Occupation:___________________________________

Referred to this Office By:____

Name and Number of Emergency Contact: ___________________________ Relationship:___________

Who is responsible for your bill: ☐Self ☐Spouse ☐Workers Comp ☐Auto Insurance ☐Medicare
☐Personal Health Insurance (Name)____________________ ID#:________________ Group:_______

Insured Person's Name:______________________ Insured's Date of Birth: ____________________

Current Health Conditions

What health concerns brought you here today?____

Other Doctors Seen for This Condition: ☐Yes ☐No If yes, Name: ______________________________

Type of Treatment: __________________________ Results: _______________________________

When Did This Condition Begin:________________ Condition Has Occurred Before: ☐Yes ☐No

Is Condition: ☐Job Related ☐Auto Accident ☐Home Injury ☐Fall ☐Other

If Work or Auto Accident, Date:___________ Time:________ **See Front Desk, Additional Paperwork Required**

Medications You Currently Take: ☐Pain Killers/Muscle Relaxers:_______☐Anxiety/Depression: ______

☐Blood Pressure:________ ☐Digestive Medication:_____________☐Insulin ☐Other:_____________

Vitamins/Supplements Currently Taking:____

Past Health History

Please Check and Describe:
Major Surgery/Operations: ☐Appendectomy ☐Tonsillectomy ☐Gall Bladder ☐Hernia
☐Back Surgery ☐Broken Bones ☐Other____

Major Accidents/Falls (even if you do not think they are related to your complaint(s) above):____

Hospitalization: ____

Previous Chiropractic Care: ☐None ☐Doctor's Name & Approximate Date of Last Visit____

Below are conditions which may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

☐Pneumonia ☐Mumps ☐Influenza ☐Rheumatic Fever ☐Small Pox ☐Pleurisy
☐Polio ☐Chicken Pox ☐Arthritis ☐Tuberculosis ☐Diabetes ☐Epilepsy
☐Cancer ☐Anemia ☐Eczema ☐Whooping Cough ☐Heart Disease ☐Lumbago
☐Measles ☐Thyroid ☐Mental Disorders

Intake:
☐Coffee ☐Tea ☐Alcohol ☐Cigarettes ☐White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL
☐Low Back Pain
☐Pain Between Shoulders
☐Neck Pain
☐Joint Pain/Stiffness
☐Walking Problems
☐Difficult Chewing/Clicking Jaw
☐General Stiffness

NERVOUS SYSTEM
☐Nervous/Anxiety
☐Numbness
☐Paralysis
☐Dizziness
☐Forgetfulness
☐Confusion/Depression
☐Fainting
☐Convulsions
☐Cold/Tingling Extremities
☐Stress

GENERAL
☐Fatigue
☐Allergies
☐Loss of Sleep
☐Fever
☐Headaches

GASTRO-INTESTINAL
☐Poor/Excessive Appetite
☐Excessive Thirst
☐Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps
☐ Gas/Bloating After Meals
☐ Heartburn/Indigestion
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY
☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

CARDIOVASCULAR
☐ Chest Pain
☐ Short Breath
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

EARS, EYES, NOSE, THROAT
☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

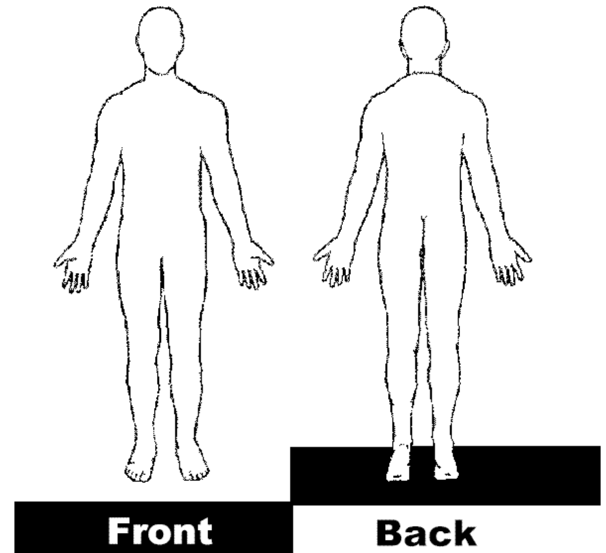
MALE/FEMALE
☐ Prostate/Sexual Dysfunction
☐ Menstrual Irregularity
☐ Menstrual Cramps
☐ Vaginal/Pain Infection
☐ Breast Pain/Lumps
☐ Other Problems
☐ ______________________
☐ ______________________
☐ ______________________

FEMALES ONLY:
When was the first day of your last period?_______________

Are you pregnant?
☐ Yes ☐No ☐Not Sure

FAMILY HISTORY
The following members have a same or similar problems as I do:
☐ Mother
☐ Father
☐ Brother
☐ Sister
☐ Spouse
☐ Child

Please circle on the diagram the area of your discomfort



Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired:

☐Relief Care ☐Corrective Care ☐Check here if you want the Doctor to select the type of care appropriate for your condition.

_________________ ____

Date Patient's Signature

Relief Care

Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

OFFICE POLICY AND RULES

1. I agree to follow my recommended treatment program. I understand that I will be expected to make up any missed appointments. All missed appointments must be made up within seven (7) days **or** at the end of my current treatment schedule. Failure to make up any missed appointment will results in a service charge of $25 and will be billed to me directly and is not payable by insurance, lien, workers compensation, etc.

2. I agree to follow the doctor's recommended treatment program. I understand in doing so I will be more likely to get the results that I am deserving of.

3. I agree to make a personal financial agreement and promptly fill out all necessary medical/legal and insurance forms to aid in the timely payment for my care

4. I understand that if my insurance company has not paid my claim within sixty (60) days, a copy of that unpaid claim will be given to me and I will be responsible to follow up on the status of payment.

5. I have read and understand, "The Notice of Privacy Practices for my Protected Health Information."

______________________________________ _________________________ ____________

Signature of Responsible Party, Parent or Guardian Patient name if not responsible party Date

______________________________________ ____________

Witness Date