

## ABOUT THE PATIENT

Name \_\_\_\_\_ Gender \_\_\_\_ M \_\_\_\_ F Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Number of children \_\_\_\_\_

Marital Status Married \_\_\_\_ Single \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_ Widowed \_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? \_\_\_\_\_

Have you been adjusted by a Chiropractor before? Yes \_\_\_\_\_ No \_\_\_\_\_

Reason for those visits? \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Approximate Date of Last Visit \_\_\_\_\_

Has any *adult* in your family seen a Chiropractor? Yes \_\_\_\_\_ No \_\_\_\_\_

Has any *child* in your family seen a Chiropractor? Yes \_\_\_\_\_ No \_\_\_\_\_

## OWNERSHIP OF X-RAYS

It is understood and agreed that the payments to the Doctor for x-rays is for 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.

## AUTHORIZATION FOR CARE

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

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all 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 me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

\_\_\_\_\_  
Patient's signature Date Parent/guardian Signature Authorizing Care Date

Primary Complaint(s):

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Please describe your condition when it is at its worse:

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**PLEASE NOTE THE APPROPRIATE RESPONSE**

Overall frequency of complaint: (circle one please)

Constantly – 100 % of the time    Frequent – 75%    Intermittent – 50%    Occasional – 25%

Overall Intensity of complaint: (check one please)

- 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 activity)

Is your problem affecting any other areas of your body? If yes explain:

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Does it interfere with your normal daily activities (work, family, recreation)?

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What aggravates the problem?

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What relieves the problem; what have you tried for relief?

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

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Any questions or concerns? \_\_\_\_\_

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**Please check all symptoms you have had in the past year, even if they do not seem related to your current problem.**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Back Pain               | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Buzzing in ears        | <input type="checkbox"/> Ringing in ears         | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Numbness in toes       | <input type="checkbox"/> Loss of taste           | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Depression             | <input type="checkbox"/> Irritability            | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Neck stiff             | <input type="checkbox"/> Cold hands              | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Hot flashes     |
| <input type="checkbox"/> Cold sweats            | <input type="checkbox"/> Lights bother eyes     | <input type="checkbox"/> Problem urinating       | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood swings            | <input type="checkbox"/> Menstrual pain         | <input type="checkbox"/> Menstrual irregularit__ | <input type="checkbox"/> Ulcers          |

List any medications you are taking \_\_\_\_\_  
\_\_\_\_\_

As your chiropractic office we are not only interested in your health and well-being, but also the health of your spine and nervous system. As your wellness center, we provide other services as well. Please indicate your interests by circling below.

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|---|---|
| <input type="checkbox"/> Health without Medications       | <input type="checkbox"/> Alternative Medicine               |
| <input type="checkbox"/> Diet (Secrets of Healthy Living) | <input type="checkbox"/> Education (Research & Newsletters) |
| <input type="checkbox"/> Weight Loss                      | <input type="checkbox"/> Exercise                           |
| <input type="checkbox"/> Improved Nutrition               | <input type="checkbox"/> Massage                            |

**Have you ever:**

- |   |  |
|---|--|
| <input type="checkbox"/> Bought bottled water             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Belonged to a health club        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Consumed vitamins or supplements | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**What aspects of wellness do you want for yourself?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> More energy                      | <input type="checkbox"/> Better sleep   | <input type="checkbox"/> Freedom from pain               |
| <input type="checkbox"/> Better concentration             | <input type="checkbox"/> Enhanced emotional well-being                        | <input type="checkbox"/> Reduce/eliminate medication use |
| <input type="checkbox"/> Improved digestion               | <input type="checkbox"/> Improved strength & endurance                        | <input type="checkbox"/> Greater resistance to disease   |
| <input type="checkbox"/> Deeper relaxation                | <input type="checkbox"/> Better sports performance,<br>reaction time/reflexes | <input type="checkbox"/> Overall health improvement      |
| <input type="checkbox"/> Easier breathing, deeper breaths | <input type="checkbox"/> More balanced posture                                |  |