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Patient Name _____ (Last) _____ (First) _____ (M.I.)

Male ☐ Female ☐ I would prefer to be called: _____

Birthdate _____ Age _____ SS# [redacted]

Street Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile _____

Email Address _____

Occupation _____

Employer _____ How Long? _____

Employer Address _____

City _____ State _____ Zip Code _____

Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name _____ Number of children? _____

Who may we thank for your referral? _____ PCP _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No Name

Your Health History

Date of last:

Physical Exam _____ X-Ray _____

Spinal Exam _____ MRI, CT or Bone Scan _____

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain Killers (including aspirin) ☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other (s) _____

Place a mark on "Yes" or "No" to indicate if you've had any of the following:

AIDS/HIV	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Other Headaches	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Digestive Disorder	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Numbness	☐ Yes ☐ No	Other	
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	_____	
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	_____	
Fractures	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please describe any injuries or surgeries you have had:

_____

_____

Your Concerns

What is your major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Other doctor(s) that treated you for this condition:

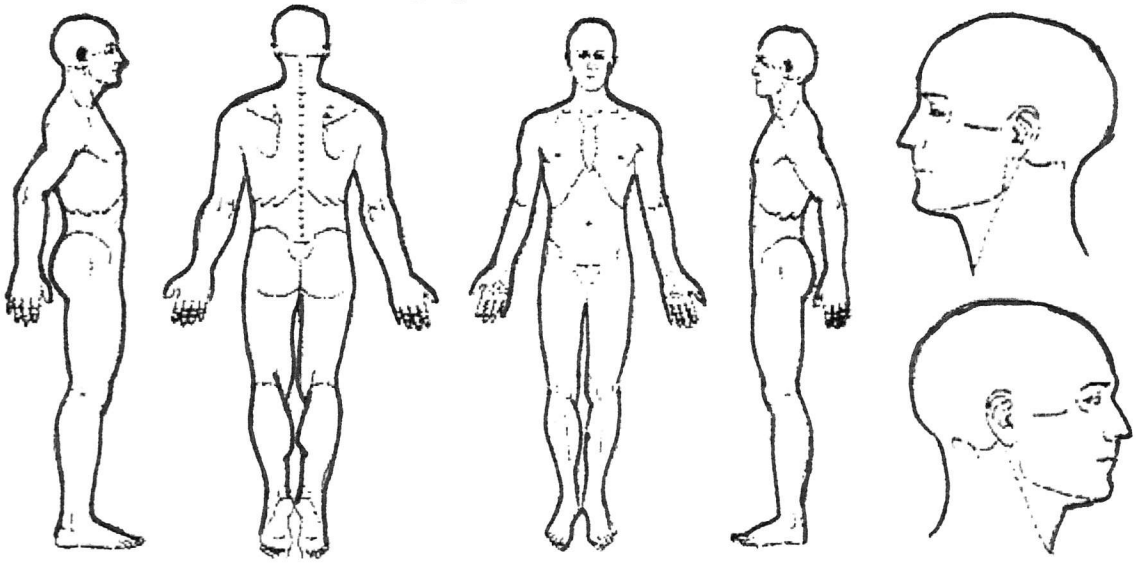
Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of pain:

☐ **S**harp ☐ **D**ull ☐ **Th**robbing ☐ **A**ching ☐ **Sh**ooting

☐ **B**urning ☐ **N**umbness ☐ **T**ingling ☐ **St**iffness ☐ **O**ther

Place appropriate highlighted letters to mark the areas of discomfort



How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

Does it interfere with Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Who else have you seen for this problem? _____

Other comments or concerns regarding your condition:

_____

Insurance Info: Primary Insurance carrier _____ ID _____

Secondary Insurance carrier _____ ID _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor(s) to work with my condition through the use of adjustments, as he or she 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 also understand that if I suspend or terminate my care, any fees will become immediately due and payable. 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 prepare 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 on receipt.

Patient or Guardian Signature: _____ Date: _____