

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:**

- |                                    |                                      |   |  |  |                                   |
|------------------------------------|--------------------------------------|---|--|--|-----------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Influenza        | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio     | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Anemia      | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago  |
| <input type="checkbox"/> Measles   | <input type="checkbox"/> Thyroid     | <input type="checkbox"/> 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?

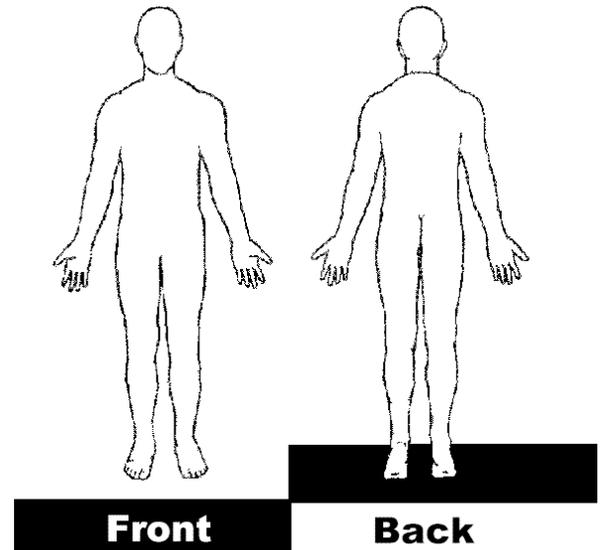
- Yes  No  Not Sure

**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 result 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