

We appreciate the opportunity to help you get back to the health. The more accurate and complete the information you give us, the better service we can give you.

Date: _____ Patient # _____ (assigned by office)

Name: _____ Social Security # _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Fax # _____ Cell Phone: _____

Age: _____ Birth Date: _____ Marital: M S W D How many children? _____

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint and/or Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ Is this due to: Auto ___ Work ___

Describe the injury/accident _____

Have you ever had the same or a similar condition? _____ If yes, when and describe: _____

Other doctors you have consulted for this condition: _____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Coughing Blood |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Ulcers <input type="checkbox"/> Depression |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Hernias | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Cancer _____ |

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____

Do you use any tobacco products? ___ Do you smoke? ___ If so, packs per day: _____

Do you take vitamin supplements? ___ If so, please list: _____

Do you consume caffeine? ___ If so, how much per day: _____

Do you exercise? ___ If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting ___ sitting ___ bending ___ working at a computer _____

FAMILY HISTORY:

Father: Current age if still living: ___ Cause of death and age at death if deceased: _____

Mother: Current age if still living: ___ Cause of death and age at death if deceased: _____

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis _____	Cancer _____	Mental Illness _____
Diabetes _____	Asthma _____	Heart Disease _____
Stroke _____	Kidney Disease _____	Lung Disease _____
Arthritis _____	Liver Disease _____	
Other _____		

Please check any and all insurance coverage that may be applicable in this case:

___ Major Medical ___ Worker's Compensation ___ Medicaid ___ Medicare ___ Auto Accident

___ Medical Savings Account & Flex Plans ___ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

SUMMARY

1. What is your major symptom? _____

Please place an "X" on the line below to indicate level of problem.

NO SYMPTOMS _____ EXTREME SYMPTOMS

2. What does this prevent you from doing or enjoying? _____

3. If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___

If yes, when and how? _____

4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___

How long does it last? All Day ___ Few Hours ___ Minutes ___

5. Are there any other conditions or symptoms that may be related to your major symptom?

Yes ___ No ___. If yes, describe: _____

Are there other unrelated health problems? Yes ___ No ___. If yes, describe _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___

Burning ___ Stabbing ___ Other _____

7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____

_____. If no, what have you tried to do that has not helped? _____

8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___

Lifting ___ Twisting ___ Other _____

9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes ___ No ___ Uncertain ___

11. Recent Diagnostic testing. List area evaluated, date, where performed

X-rays _____

MRI _____

Other _____

12. Additional comments: _____

In addition to the above described health concern(s), please identify any other health concerns you have experienced:

- ___ Headaches ___ Neck Pain ___ Shoulder Pain ___ Carpal Tunnel Syndrome
___ Low Back Pain ___ Sciatica ___ Hip/Leg Pain ___ Foot Pain
___ Fatigue ___ Fibromyalgia ___ Arthritis ___ Numbness/Tingling

Patient's Signature _____ Date _____