

# WELCOME!

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

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

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Work Phone # \_\_\_\_\_ Employer's Address \_\_\_\_\_

Marital Status: ( )Single ( )Married ( )Divorced Spouse's Name \_\_\_\_\_

# of children and ages \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Have you ever been treated by a Chiropractor before? ( )Yes ( )No If so Whom? \_\_\_\_\_

\_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Your Ins. Co. \_\_\_\_\_ Group # \_\_\_\_\_

Ins Co. Address \_\_\_\_\_

Ins Co. Phone # \_\_\_\_\_

Person Ultimately Responsible for Account (Name and Address if different from above) \_\_\_\_\_

\_\_\_\_\_

## REASON FOR VISIT

The reason for this visit is a result of (Please Circle): Work Sports Auto Trauma Chronic

Explain what Happened: \_\_\_\_\_

\_\_\_\_\_

**Drs. Notes** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe the pain and its location: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Drs. Notes** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did the condition begin? \_\_\_ / \_\_\_ / \_\_\_

On a scale of 0-10 please rate your pain (0=no pain, 10=extreme pain) \_\_\_\_\_

Is this condition getting worse? ( )Yes ( )No ( )Constant ( )Comes and Goes

Is this condition interfering with your (Please Circle): Work Sleep Daily Routine?

If so, please explain \_\_\_\_\_  
\_\_\_\_\_

Do you have a prior history of similar complaints? \_\_\_\_ If yes, dates, prior treatment, results, etc. \_\_\_\_\_  
\_\_\_\_\_

**Drs. Notes** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated by a Medical Physician for this condition? ( )Yes ( )No

If so, where? \_\_\_\_\_

For what condition? \_\_\_\_\_

Please describe any additional complaints: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever had any of the following diseases/medical conditions?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke        | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Heart Murmur      |
| <input type="checkbox"/> Congenital Heart Defect    | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Alcohol/Drug Abuse         | <input type="checkbox"/> Venereal Disease        | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> HIV+/ Aids                 | <input type="checkbox"/> Shingles                | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Frequent Neck Pain         | <input type="checkbox"/> Emphysema/Glaucoma      | <input type="checkbox"/> Anemia            |
| <input type="checkbox"/> High/Low Blood Pressure    | <input type="checkbox"/> Psychiatric Problems    | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Severe/Frequent Headaches  | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ulcers/Colitis    |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Diabetes/Tuberculosis      | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Chemotherapy      |
| <input type="checkbox"/> Lower Back Problems        | <input type="checkbox"/> Hypothyroid             | <input type="checkbox"/> Hyperthyroid      |
| <input type="checkbox"/> Artificial Bones/Joints    | <input type="checkbox"/> Arthritis               |  |

Please List any other serious medical condition(s) you have or ever had: \_\_\_\_\_  
\_\_\_\_\_

Please list anything that you may be allergic to \_\_\_\_\_

List previous surgeries/treatment with dates: \_\_\_\_\_  
\_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_  
\_\_\_\_\_

Family Health History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Women:** Are you Pregnant? ( )Yes ( )No Nursing? ( )Yes ( )No

Date of Last Menses: \_\_\_/\_\_\_/\_\_\_

**Are you taking any of the following medications?**

- Nerve Pills  Pain Killers (Including Aspirin)  Muscle Relaxants  Stimulants  
 Blood Thinners  Tranquilizers  Insulin  Birth Control Pill  Other \_\_\_\_\_

**HABITS & ACTIVITY**

Do you or have you ever smoked? ( )yes ( )No Packs per day: \_\_\_\_\_

Do you or have you ever used alcohol? ( )Yes ( )No Amount/Type\_\_\_\_\_

Do you drink caffeinated beverages? ( )Yes ( )No How much and type: \_\_\_\_\_

Regular Exercise? ( )Yes ( )No Activity and intensity: \_\_\_\_\_

Do you feel you eat a well balanced diet? ( )Yes ( )No

Are you interested in a complete nutritional profile to assess your specific nutritional needs? ( )Yes ( )No

Are there any particular activities of daily living that you are having difficulty with due to your presenting complaint(s)?\_

\_\_\_\_\_

**Drs. Notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IN THE EVENT OF EMERGENCY**

Who should we contact?\_\_\_\_\_ Relation\_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone#\_\_\_\_\_

Who is your Medical Doctor?\_\_\_\_\_ Phone #\_\_\_\_\_

\_\_\_\_\_

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

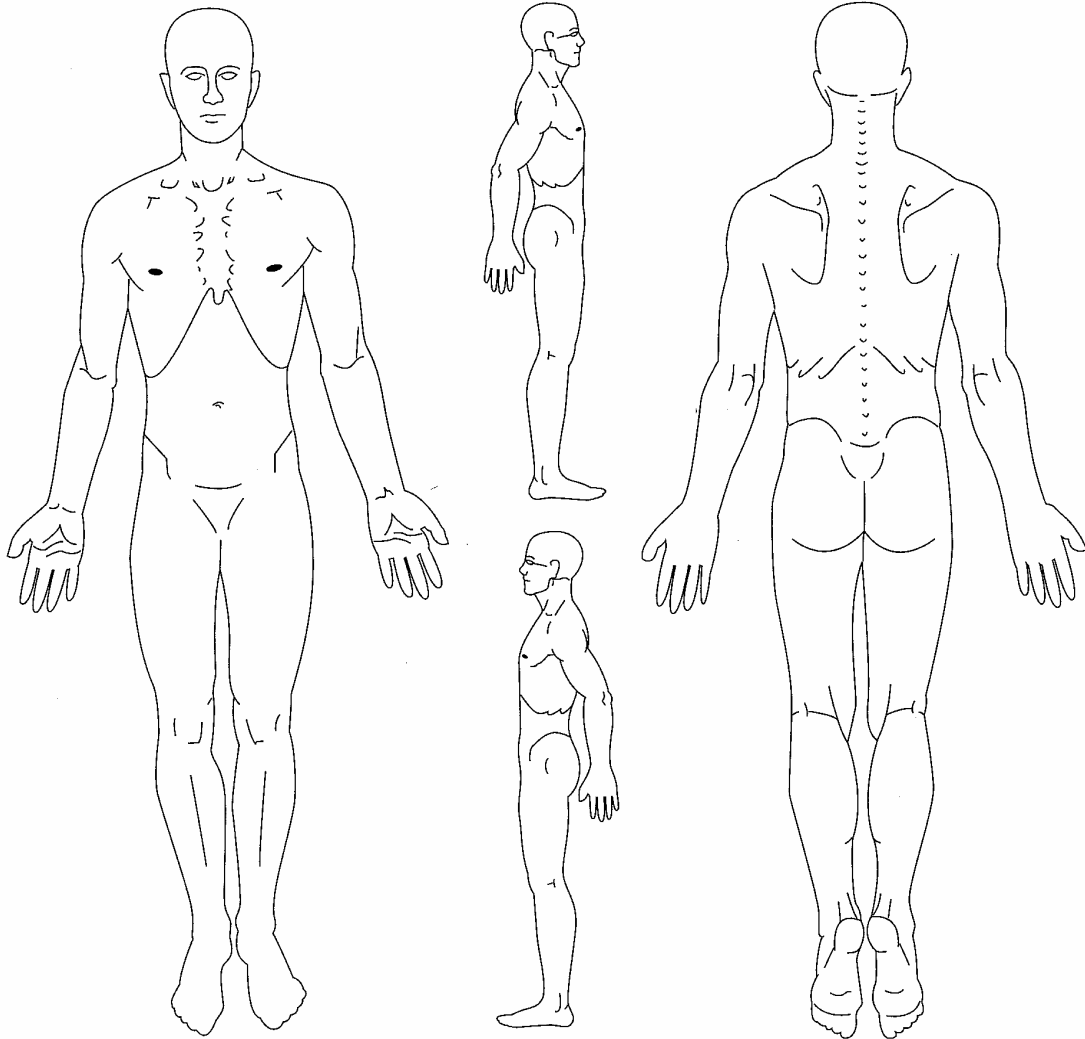
Signature\_\_\_\_\_ Date\_\_\_\_\_

Patient Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient ID # \_\_\_\_\_

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

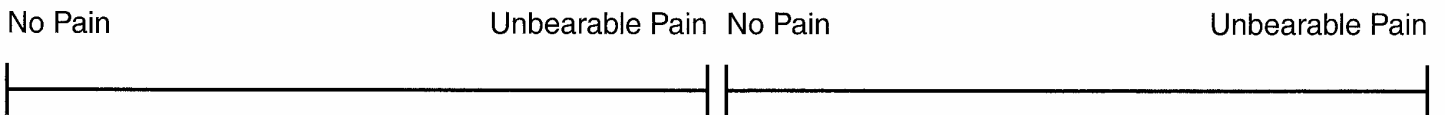
- D** = Dull
- B** = Burning
- N** = Numb
- S** = Stabbing/Cutting
- T** = Tingling (Pins & Needles)
- C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:

