Today's Date: ____/___/_____

CONFIDENTIAL HEALTH INFORMATION

PATIENT DEMOGRAPHICS

Name:_____ Birth Date:___/___/_____ Age:_____
(Last) (First) (M.I.)

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

E-mail:_____ Home Phone:_____ Cell:_____

Marital Status: Single___ Married___ Divorced ___ Other_____ Sex: Male ___ Female___ Other_____

Spouse's Name: _____ Number of Children:_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Whom may we thank for referring you? _____

PAYMENT INFORMATION

Method of Payment: Cash ____ Check ____ Credit/Debit ____ Auto ____ Workers Comp: ____

Insurance Company: _____ Member ID/Claim Number: _____

HISTORY OF COMPLAINT

Why are you here? Please describe your major complaint: _____

_____

_____

_____

_____

Please check if applicable: Work related injury ____ No fault/Auto Injury ____ How did injury happen? _____

_____

Approximate date of when your problem started: _____

Have you had this problem or similar in the past? Yes ____ No ____ If yes, when was last time? _____

Are your complaints affecting your ability to be active? Yes ____ No ____ If yes, explain: _____

_____

Frequency of Pain/Discomfort: Constant (75-100%) ___ Frequent (51-74%) ____ Occasional (26-50%) ___ Intermittent _____

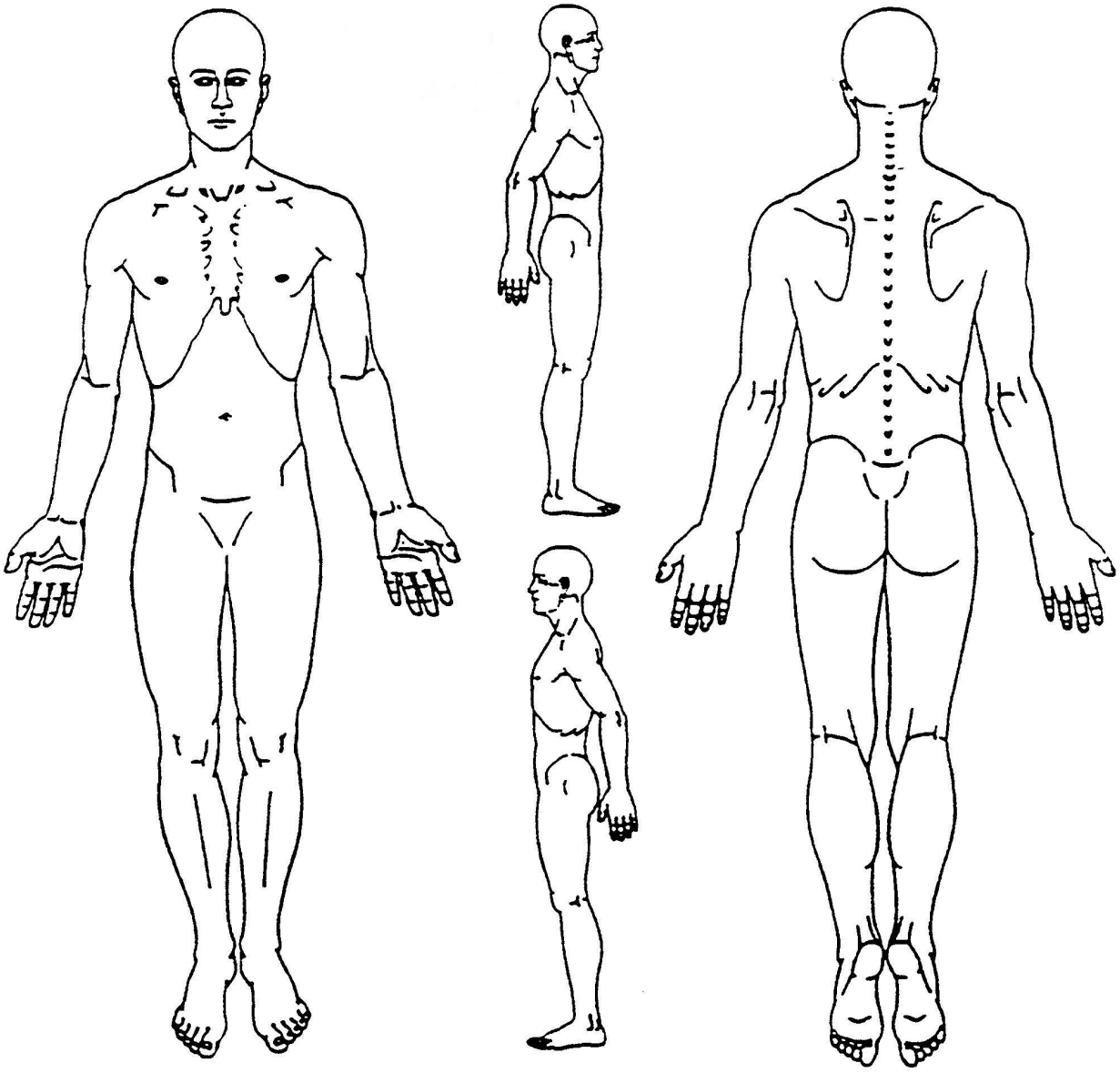
What do you want out of your healthcare experience?

Relief Care (patch the problem) _____ Corrective Care (fix the problem) ____

PAIN DRAWING

Please mark the drawings below according to where you hurt. Indicate which sensations you are currently experiencing by referring to the key below:

SS = Stabbing **BB** = Burning **PP** = Pins & Needles **NN** = Numbness **AA** = Aching **OO** = Other



Current Pain Level (please circle): 0 1 2 3 4 5 6 7 8 9 10

0	No Pain
1	Mild Pain. You are aware of it, but it doesn't bother you.
2	Moderate Pain. You can tolerate without medication.
3	Moderate Pain. It requires medication to tolerate.
4 – 5	More Severe Pain. You begin to feel antisocial.
6	Severe Pain
7-9	Intensely Severe Pain
10	Most Severe/Excruciating Pain

HEALTH HISTORY

Have you had any previous Chiropractic care: Yes ____ No ____ Approximate date of last visit: _____

Dr.'s Name: _____

Have you had any diagnostic studies (X-ray, MRI, CT, Bone Scan, etc.) in the last 2 years? Yes ____ No ____

X-ray ___ MRI ___ CT ___ Other: _____ Approximate date and facility: _____

Please mark any of the conditions that you previously or currently have. Mark current with a C and previous with a P:

Musculoskeletal:

Neck pain ___ Back pain ___ Shoulder pain ___ Elbow /hand pain ___ Hip pain ___ Knee/ ankle pain ___

Arthritis ___ Osteoporosis ___ Scoliosis ___

Neurological:

Headaches ___ Migraines ___ Anxiety ___ Depression ___ Sleep problems ___

Cardiovascular:

High blood pressure ___ Low blood pressure ___ Angina ___ Heart attack ___ Stroke ___ Poor circulation ___

Respiratory :

Asthma ___ Pneumonia ___ Emphysema ___ Sleep apnea ___ Allergies ___

Digestive

Irritable bowel ___ Constipation ___ Diarrhea ___ Ulcers ___ Food sensitivities/allergies ___ Heartburn

Nausea ___ Anorexia/bulimia ___

Sensory

Blurred vision ___ Ringing/buzzing in ears ___ Hearing loss ___ Loss of smell___ Loss of taste ___ Loss of touch ___

Integumentary

Skin cancer ___ Psoriasis ___ Eczema ___ Acne ___ Rashes ___ Hair loss ___

Endocrine

Immune disorders ____ Diabetes ___ Thyroid issues ___ Fatigue ___

Genitourinary

Kidney stones ___ PMS symptoms ___ Prostate issues ___ Bowel/bladder control issues ___

_____

Please list any allergies that you have: _____

_____

_____

Medications you are currently taking:

Drug Name **Frequency**

_____

_____

_____

Present Weight: _____ lbs. Height:____feet _____inches Blood Pressure: High Low Normal? ____ /_____

CONFIDENTIAL HEALTH INFORMATION

Informed Consent

Chiropractic: The science of locating and correcting subluxations

Subluxations: An alteration of normal spinal alignment or aberrant joint motion causing nerve interference, reflex muscle spasm and often pain and disability.

Adjustment: The application of force to bones of the spine (or extremities), which causes a change in alignment towards normal position.

Benefits of Chiropractic Care: Less pain, less disability, increased range of motion, better functioning nervous system.

Risks of Chiropractic Care: Adjustments occasionally cause initial soreness.

The working diagnosis, prognosis, proposed care plan, risks and benefits have been fully explained to me.
I have been given the opportunity to ask questions.

I agree to be examined and I accept care on this basis as explained to me.

_____ _____

Signature Date

_____

Print Name