What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ○ no ○ yes

If yes, please describe _____

_____

_____

Do any friends or relatives see chiropractors? ○ no ○ yes

If yes, do they use chiropractic for ○ health maintenance/optimization

○ health problems ○ both

Are you seeking chiropractic for ○ health maintenance/optimization

○ health problems ○ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you?

○ no ○ yes If yes, please tell us. _____

_____

_____

Notes _____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care?

○ Cash ○ Check ○ Credit Card # _____ Exp. _____

Insurance co. _____ Group Policy # _____

Address _____ Phone # _____

Insured's name _____

Relation _____ Insured's employer _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)

CHIROPRACTIC

Bringing Out The Best In You

○ New Patient

Welcome To Our Office

Patient _____

Doctor _____

Date _____ *Case #* _____

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Is it okay to contact you at work? ○ no ○ yes Work # _____

E-mail address _____ Web site _____

SS# _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Marital status ○ single ○ married ○ separated ○ divorced ○ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

Do you have any pets? ○ no ○ yes If yes, please tell us what kind(s) _____

_____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

Favorite hobbies or interests _____

What Brings You Here?

Have you ever had chiropractic care before? ○ no ○ yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? ○ no ○ yes

How did you find out about our office? _____

Is this appointment related to ○ work ○ sports ○ auto

○ personal injury ○ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? ○ no ○ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ○ no ○ yes If yes, what month? _____

This form continues. Please turn the page.

Current Health

What are your most pressing health concerns? _____

_____

_____

For how long? _____

Is it ○ getting worse ○ improving ○ intermittent ○ constant ○ can't say

Where is the problem? Please use the illustrations and lines below to explain.

○ Front _____

_____

_____

_____

○ Back _____

_____

_____

_____

Do you have ○ pain ○ numbness ○ tingling ○ aches

Is your pain ○ sharp ○ dull ○ throbbing ○ constant ○ intermittent

Are your symptoms affected by ○ sitting ○ standing ○ walking ○ bending ○ lying down ○ weather

Please explain _____

Do you feel ○ cramps ○ burning ○ other ○ swelling ○ stiffness _____

Do your symptoms interfere with ○ work ○ sleep ○ other ○ day-to-day activities ○ play _____

Please explain _____

_____

On a scale of 1-10 *(1 least, 10 most)*, please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Do you have, or have you had, any of the following (*please check ✓ all that apply*)

○ pneumonia	○ mumps	○ influenza	○ rheumatic fever	○ smallpox
○ pleurisy	○ polio	○ chickenpox	○ thyroid disease	○ diabetes
○ epilepsy	○ cancer	○ depression	○ whooping cough	○ anemia
○ eczema	○ measles	○ arthritis	○ heart disease	○ rashes

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you use ○ coffee ○ tea ○ artificial sweeteners ○ sugar ○ alcohol ○ cigarettes ○ recreational drugs

Have you ever suffered from (*please check ✓ all that apply*)

○ neck pain	○ stuffy nose	○ discolored urine
○ low back pain	○ allergies	○ gas/bloating after meals
○ headache	○ fainting	○ heartburn
○ migraines	○ weight loss	○ colitis
○ arm back/tingling	○ poor appetite	○ irritable bowel
○ shoulder pain	○ excessive appetite	○ black or bloody stools
○ hand pain/tingling	○ nervousness	○ constipation
○ leg pain/tingling	○ confusion	○ hemorrhoids
○ jaw pain	○ depression	○ liver problems
○ chest pain	○ dental problems	○ stroke
○ lung problems	○ excessive thirst	○ paralysis
○ heart problems	○ frequent nausea	○ tingling
○ abnormal blood pressure	○ vomiting	○ numbness
○ irregular heartbeat	○ prostate problem	○ fatigue
○ ankle swelling	○ breast pain/lump	○ dizziness
○ cold extremities	○ cramps	○ loss of sleep
○ blurred vision	○ painful urination	○ difficulty hearing
○ vision problems	○ bladder trouble	○ ear pain
○ difficulty breathing	○ excessive urination	

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check ✓ all that apply*)

○ falls/accidents	○ head injuries	○ fights
○ sports injuries	○ broken bones	○ dislocations
○ spinal tap	○ surgery	○ traction
○ use(d) a cane or walker	○ extensive dental work	○ dental appliances
○ knocked unconscious		

If yes to any of the above, please describe _____

_____

_____