

## ABOUT YOU

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

Line 2 -  
Apartment  
Number \_\_\_\_\_

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

Mobile Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Home Phone \_\_\_\_-\_\_\_\_-\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender  Male  Female

Height \_\_\_\_' \_\_\_\_" Weight \_\_\_\_\_ lbs

Marital Status  Single  Married  Separated  Divorced  Widowed  Other

Number of Children \_\_\_\_\_ Spouse's Name \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION.

Name \_\_\_\_\_

Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Relation To You \_\_\_\_\_

## INSURANCE INFORMATION

Do you have Insurance?  Yes  No

Insurance Name \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_-\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

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

ID/Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

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

## REFERRAL INFORMATION

Referring Physician \_\_\_\_\_ Contact information. \_\_\_\_\_

Referring Patient \_\_\_\_\_

Are you working with an attorney?  Yes  No

How did you hear about us?

Word of mouth  Advertisement  Social media  Direct marketing  Internet

## REASON FOR VISIT

What is the date of your scheduled appointment? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

How long have you had this complaint?

- Less than 5 days (Acute)
- Between 5-30 days (Sub Acute)
- More than 30 days (Chronic)

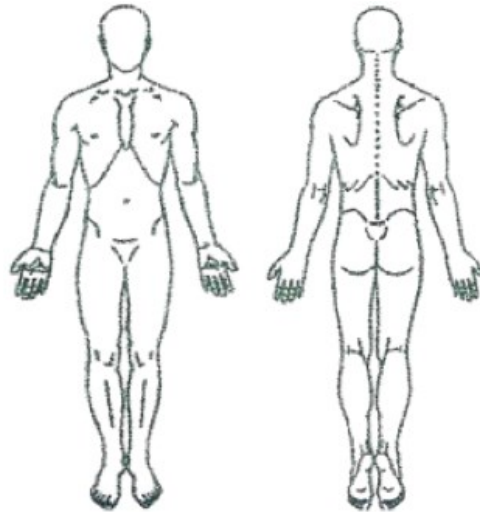
What caused this condition \_\_\_\_\_

What is the date this condition began? (Skip if due to accident) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What term(s) describes your discomfort best? \_\_\_\_\_

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

- P - pain
- N - numbness
- W - weakness
- S - shooting
- A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None                      0                      1                      2                      3                      4                      5                      6                      7                      8                      9                      10                      Unbearable

How often do you feel this discomfort?  Constant  Frequent  Occasional  Intermittent

How has this complaint changed since the onset?  Worsened  Remained the same  Improved

What activity is most significantly affected by this discomfort? (Explain) \_\_\_\_\_

What treatment, if any, have you received since the accident? \_\_\_\_\_

**What aggravates this condition?** \_\_\_\_\_

**What improves this condition or gives you relief?** \_\_\_\_\_

**Have other health care provider(s) performed tests related to this condition?** \_\_\_\_\_

**Have you ever had any previous episodes of this condition?** \_\_\_\_\_

## CURRENT HEALTH

**Other than the information already provided, do you have additional health concerns involving any of the following?**

**Muscles, Bones or Joints**  No  Yes **Explain:** \_\_\_\_\_

**Nerves, Headaches, Dizziness, or Emotional**  No  Yes **Explain:** \_\_\_\_\_

**Head, Eyes, Ears, Nose or Throat**  No  Yes **Explain:** \_\_\_\_\_

**Heart, Blood Pressure, or Circulation**  No  Yes **Explain:** \_\_\_\_\_

**Shortness of Breath, Coughing, Asthma or Lung Condition**  No  Yes **Explain:** \_\_\_\_\_

**Stomach, Bowels or Digestive Conditions**  No  Yes **Explain:** \_\_\_\_\_

**Genital, Bladder, or Urinary Conditions**  No  Yes **Explain:** \_\_\_\_\_

**Diabetes, Thyroid or Glandular Conditions**  No  Yes **Explain:** \_\_\_\_\_

**Skin or Bleeding Conditions**  No  Yes **Explain:** \_\_\_\_\_

**Allergies or Sensitivities**  No  Yes **Explain:** \_\_\_\_\_

## PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures?  No  Yes Explain: \_\_\_\_\_

Are there any past illnesses or conditions we should be aware of?  No  Yes Explain: \_\_\_\_\_

Do you have a past history of accidents or trauma?  No  Yes Explain: \_\_\_\_\_

Are there any past illnesses or conditions we should be aware of?  No  Yes Explain: \_\_\_\_\_

Are you presently taking any medication?  No  Yes Explain: \_\_\_\_\_

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?  No  Yes Explain: \_\_\_\_\_

## WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- Permanently fully disabled
- Permanently partially disabled
- Cannot work due to current condition
- Full-time (20-40+ hours/week)
- Part-time (1-19 hours/week)
- Retired  Student  Homemaker  Unemployed

Personal social habits - Choose all that apply.

- Smoke or use tobacco products
- Drink alcohol
- Drink caffeine
- Use recreational drugs
- Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- No current exercises
- Exercises daily
- Exercises 3+ times per week
- Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- Vegan or vegetarian
- Daily supplements
- Other



## MEN'S HEALTH

**Do you have pain or lump in scrotum or testicles?**  Yes  No

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**Do you have an impaired libido (sex drive)?**  Yes  No

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**Do you have discharge from your penis?**  Yes  No

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**Do you have prostate issues?**  Yes  No

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**When was your last prostate exam?**  Within the past year  Between 1-4 years  
 Greater than 5 years  Never had a prostate exam  
 Prefers not to answer or don't know

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**When was your most recent PSA (Prostate-Specific Antigen) blood test?**  Within the past year  Between 1-4 years  
 Greater than 5 years  Never had a PSA blood test  
 Prefers not to answer or don't know

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**What was your PSA (Prostate-Specific Antigen) level on your latest test?**  Normal or low  Moderate  
 High  Never had a PSA level done  
 Prefers not to answer or don't know

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## WOMEN'S HEALTH

Are you pregnant?  Yes  No

Are you nursing?  Yes  No

Are you taking birth control?  Yes  No

Do you experience painful periods?  Yes  No

Do you have irregular cycles?  Yes  No

Do you have breast implants?  Yes  No

Do you perform a regular self-breast examination?  Yes  No

Do you take hormone replacement therapy (HRT)?  Yes  No

Do you take oral contraceptives?  Yes  No

When was your last PAP/pelvic exam?  Within the past year  
 Between 1-4 years  
 Greater than 5 years  
 Never had a PAP or pelvic exam  
 Prefers not to answer or don't know

Within the past year  
 Between 1-4 years  
 Greater than 5 years  
 Never had a mammogram exam  
 Prefers not to answer or don't know

What was the date of your last menstrual period? (only answer if still menstruating)  Within the past month or currently  
 Within the past 1-3 months  
 Greater than 3 months  
 Postmenopausal  
 Have not yet begun menstruation  
 Prefers not to answer or don't know



## INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_