Welcome To Our Office

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

PERSONAL INFORMATION:

Name Preferred Name		Referred by	Home Phone
Address		Occupation	Cell Phone
City / State / Zip		Employment	Work Phone
Age Sex	Date of Birth	Marital Status	# of Children
Social Security Number	Driver's License #	Spouse's Name	Spouse's Date of Birth
Spouse's Occupation	Spouse's Employer	Spouse's Social Security Number	
Emergency Contact (Name, relation & home & work numbers)			

INSURANCE INFORMATION:

Is this condition related to work injury? Y or N		Is this condition related to auto accident? Y or N		
Insurance Company (Primary)		Company Address (Primary)		Is this Your Employer's Plan?
Insured Person	Insured DOB	Relationship to Insured	ID Number	Group Number
Insurance Company (Secondary)		Company Address (Secondary)		Is this Your Employer's Plan?
Insured Person	Insured DOB	Relationship to Insured	ID Number	Group Number

REASON FOR VISIT:

MAJOR COMPLAINT: _____

How long have you had this condition? _____ Date began:_____

Pain Scale: (please circle)

0	1	2	3	4	5	6	7	8	9	10
No pain				Moderate pain					Unbearable pain	

Have you lost any work ? Yes ( ) No ( ) Dates: _____

Have you had this similar condition before? Yes ( ) No ( ) If yes, When? _____

List any doctors seen for this condition: _____

List any diagnosis & type of treatment(s) : _____

List the name of any relatives that have or have had a similar problem: _____

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

If yes, explain:_____ Family physician: Dr.: _____

List any serious accidents, falls, or other traumas: _____

List all medications that you are currently taking: _____

Have you been under medication in the past? Yes or No If so, what kind? _____

Please list all vitamins and supplements that you are currently taking: _____

List the approximate dates of any surgery or diseases you have had: _____

_____

LIFESTYLE: (Please check all that apply, and note frequency of use)

	Tobacco		Caffeinated beverages		Alcohol		Recreational drugs

EXERCISE : Please list types of activity and frequency_____

DIETARY HABITS: (Note frequently eaten foods)

	Vegetarian		Thirst w/out desire to drink		Cold drinks		Salty
	Raw foods diet		Fish / seafood		Hot drinks		Eggs
	Low fat diet		Chicken		Extreme thirst		Sweet
	High protein / low carb diet		Fast food / burgers / fries		Ice chewing		Spicy / hot
	Dairy products/milk/cheese		Artificial sweeteners		Red meat		Sour

CHIROPRACTIC INFORMATION:

Have you or any relative received chiropractic care previously? Yes ( ) No ( ) Dr.: _____

Why did you see this chiropractor? _____Were you helped? _____

What spinal maintenance programs were you given to maximize the future stability of your spine?_____

_____Did you follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

What do you think you should do to be healthy? _____

How do you want us to handle your problem?

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)

_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

Why did you chose our office & what are your expectations of us? _____

1. What are your favorite activities or hobbies to do?_____
2. Are your current problems affecting these activities or hobbies ? _____
3. What activities are you looking forward to doing in retirement ? _____
4. Who would you like to be doing these with ? _____

On a scale of 1 – 10 (10 being the most, and 1 being the least),

_____ How committed are you at being at your maximum health potential?

_____ How important is it for your family to be at their optimum health potential?

_____ How committed are you to preventing arthritis and maximizing your spinal stability?

Health Survey:

Please describe your health using the following codes: **1 = PREVIOUSLY had** **2 = CURRENTLY have**

If there are multiple symptoms in block, please circle your appropriate symptoms.

Musculo-Skeletal System

	Low back or Hip problems		Painful / stiff / Swollen joint		Leg problems (hip, knee, ankle, foot)
	Neck problems		Carpal tunnel / Tendonitis		Arm problems (elbow, wrist, hand)
	Back or Shoulder problems		Arthritis		Osteoporosis or Fractured Bones
	Pain between shoulders		Back curvature		Vertebral disc degeneration
	Head seems too heavy		Limited range of motion		Fibromyalgia /Chronic fatigue
	Head & shoulders feel tired		Sore or Weak muscles		Difficulty in excess (standing, walking, sitting, lifting, household duties)
	Headaches or Migraines		Jaw pain or clicking (TMJ)		

General Symptoms

	Thyroid problems		Anemia		Bleed / bruise easily
	Nervous / tension		Dizziness / vertigo		Frequent colds / flu / fatigue
	Cancer		Diabetes		Fever / chills / night sweats

Gastrointestinal System

	Belching or Excessive Gas		Acid reflux / Heartburn		Digestive problems /Abdominal pain
	Poor or No appetite		Tired after eating		Colon trouble
	Excessive appetite or Thirst		Difficulty swallowing		Nausea or Vomiting food or blood
	Craving sweets, salt, or other		Constipation / Diarrhea		Black / bloody / Mucous in stool
	Gallstone / Gall bladder problem		Liver troubles		Dieting / Obesity

Nervous System

	Light headedness upon rising		Tremor / tic / Muscle twitch		Numbness / loss of feeling / Tingling
	Loss of balance		Fainting / Seizure / Epilepsy		Pain with coughing, sneezing, or straining at stools
	Paralysis		Multiple sclerosis		

Skin / Hair System

	Eczema / Psoriasis		Dry, Itchy skin or Dandruff		Rashes / Hives / Shingles
	Fungal infections		Brittle or Ridged nails		Acne

Neuropsychological System

	Depression/ Mental disorder		Trouble sleeping / Insomnia		Irritable, Anxiety, Easily Stressed
	Lose temper easily		Job stress		Learning disability / Dyslexia
	Recent Divorce		Death of someone close		Trouble concentrating / Poor Memory

Cardiovascular / Respiratory System

	Cold hand / feet / Swollen ankle		Short of breath / Wheezing		Heart problem / heart attack / Stroke
	Rapid Heartbeat/ Chest tightness		Varicose veins / Blood Clots		Lung problems / Difficult Breathing
	High cholesterol / Heart disease		Pneumonia, Asthma, TB		Persistent Cough / Dry Cough
	Heart valve abnormality		High or Low blood pressure		Productive cough / Coughing blood

Ears, Eyes, Nose, & Throat System

	Vision problems / Eye strain		Night blindness / Glaucoma		Dry eyes / Light Bothers Eyes
	Macular degeneration / Cataracts		Blurred / double vision		Ringing in ears (tinnitus)
	Earache / Ear pain / Ear infection		Hearing Loss		Difficulty breathing thru nose
	Sinus problem / Swollen Glands		Allergies		Post – nasal drip / Nose bleeds
	Dry mouth or Excess saliva		Hoarseness / Sore Throat		Bleeding gums
	Dental problems		Filled cavities		Root canals
	Sore tongue, mouth, or gums		Other dental work: (please list)		

Genito – Urinary System

	Kidney stones / Bladder trouble		Excessive or Scanty urine		Incomplete urination / retention
	Painful / burning urination		Discolored or Bloody urine		Dribbling when laughing / sneezing
	Wake frequently to urinate		Frequent Urination		Bed wetting
	Decreased libido / Infertility		Hepatitis / Herpes		Venereal diseases (STD) / AIDS / HIV

Men Only

	Impotence		Prostate problems		Erectile dysfunction

Women Only

	Age menses began		Birth control pills		Hormone replacement therapy
	Age menses ended		Candida / Yeast infection		Vaginal discharge / Vaginal Sores
	Date of last ob/gyn exam?		Hysterectomy? Partial / Full		Ovarian cysts / Fibroids
	PMS / Cramps		No period / Irregular cycles		Fibrocystic breast / Breast pain
	Acne associated with period		Miscarriage		Menopausal problems / hot flashes
	Constipation /diarrhea associated with period		Bleeding outside of regular cycle		Emotional irritability / depression associated with period
	Pregnant (now)		Period lasts _____ days		___ Days between period (usually)
	Headache ☐ before menstrual cycle ☐ during cycle ☐ after cycle				

Have you received the COVID – 19 vaccination _____ Yes _____ No If yes, when did you receive your first shot? _____ Which vaccine did you receive? _____

Have you received any boosters and if so when: _____

Anything that you would like to add:

_____

_____

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature _____

Show Us Where It Hurts