SHELL CHIROPRACTIC, INC

Today's Date:_____

Name:_____ Preferred Name:_____

Date of Birth:_____ Age:_____ Marital Status: S M W D Spouse's Name:_____

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

Home #:_____Cell #:_____ Work #:_____

Email Address:_____ Employer:_____ Occupation:_____

Emergency Contact:_____Relationship:_____ Phone:_____

How did you hear about us? ☐Newspaper ☐Online ☐ Referral ☐Dr. Referral Referred by:_____

Have you had chiropractic care before?_____ Dr's name:_____ Number of Children:_____

SYMPTOMS

Reason for visit:_____ When did you first notice the symptoms?_____

Is this condition getting progressively worse?_____

Where specifically is(are) the problem(s) located? _____

Which activities are hard to perform? ☐Sitting ☐ Standing ☐Walking ☐Bending ☐Lying down ☐Other

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐Aching ☐ Shooting

☐ Burning ☐ Tingling ☐Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain(1 - mild pain or discomfort, 10 - severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go?_____

What treatment have you already received for your condition? ☐Medication ☐Surgery ☐ PT ☐Other

Please list all medications you are currently taking:_____

Allergies:_____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐Moderate ☐ Heavy

What do your daily work habits include? ☐Sitting ☐Standing ☐ Light labor ☐Heavy labor ☐ Computer work

Do you smoke? ☐ Yes ☐ No How much per day?_____

How much liquor do you consume on a weekly basis?_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my or my dependent's behalf.

X_____

Signature of Patient (or parent if a minor) Date