RECONNECT
CHIROPRACTIC

Name *(Last, First, M.I.):* ◻ M ◻ F			**DOB:**
Marital status: ◻ Single ◻ Partnered ◻ Married ◻ Separated ◻ Divorced			
Address:		**City:**	**State:** **Zip:**
E-mail Address:			
Contact #:			
Employer:		**Occupation:**	
Emergency Contact:	#:	**Relationship:**	
Number of Children		**Ages:**	
Who can we thank for referring you into our office:			

What would you like to gain from Chiropractic care? Resolve existing condition ☐ Wellness ☐ Both ☐

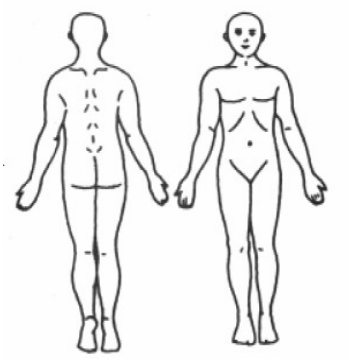
HISTORY OF COMPLAINT

What brought you in today?			
Is this a result of an auto accident?			
When did this problem begin?			
How did the injury happen?			
What relieves your symptoms?		**What makes your symptoms worse?**	
Do you feel it: (circle all that apply)	Constantly	On or off during the day/ week	Worst in Morning/ Mid-day/ Evening

Please mark and label where you are feeling your complaint:

R= Radiating B= Burning D=Dull A=Aching

N=Numbness S= Sharp/Stabbing T=Tingling



Chiropractic History:

Have you ever been adjusted? Yes No

How long were you under care? _____

Previous Chiropractor? _____

Was your family under care? Yes No

On a scale of 0-10, 10 being the worst pain you have ever experienced, what would you rate your complaint?

Right now: 0 – 1 – 2 - 3 - 4 - 5 - 6 – 7 – 8 – 9 - 10
Average: 0 – 1 – 2 - 3 - 4 - 5 - 6 – 7 – 8 – 9 - 10
At Best: 0 – 1 – 2 - 3 - 4 - 5 - 6 – 7 – 8 – 9 - 10
At worst: 0 – 1 – 2 - 3 - 4 - 5 - 6 – 7 – 8 – 9 – 10

LIST ANY OTHER HEALTHCARE PROVIDER YOU HAVE SEEN FOR THIS COMPLAINT

Year	Treatment/ Results	Provider

HEALTH HISTORY			
TYPE	HOW LONG AGO	TREATMENT	BY WHO
Injuries/Accidents			
Surgeries			
Childhood/ Adult diseases			

ANY allergies (Environmental/Food/Medical)? If yes, please explain here:

_____

_____

Please explain briefly what your daily diet consists of?

_____

How many hours of sleep do you get a night? _____ Sleep Interrupted? Y/N

List ANY medications/Prescriptions/Supplements that you are currently using:

_____

_____

FAMILY HISTORY- MARK"X" TO ALL THAT APPLIES

	GRANDMOTHER	GRANDFATHER	MOTHER	FATHER	BROTHER	SISTER
CANCER						
STROKE						
HEART CONDITION						
AUTOIMMUNE DISORDER						

ANY other hereditary conditions the doctor should be aware of? If yes, please explain here: _____

Anything else you would like the Doctor to know?

_____

_____

PLEASE MARK P= PAST, C=CURRENT, N=NEVER		
Check if you have, or have had, any symptoms in the following areas to a significant degree.		
☐ Depression	☐ Double vision/Blurred vision	☐ Convulsions/Epilepsy
▫ Headache/Migraine	▫ Numbness/Tingling in arms, hands, fingers	▫ Diabetes
▫ Dizziness/vertigo	▫ Numbness/Tingling in legs, feet, toes	▫ Rheumatoid Arthritis
▫ Frequent ear ache/infections/ringing in ear/ hearing loss	▫ Constipation/frequent bloating	▫ Energy level
☐ Gall bladder/Kidney issues	☐ Pain with coughing/Sneezing	☐ Heart problem
▫ Frequent congestion/Sinus Pressure	▫ Bladder/Bowel issues	▫ Ability to sleep
▫ Allergies/Asthma	▫ Bed Wetting	▫ Other pain/discomfort/Condition:
▫ Jaw Pain	▫ Acid reflux/Heartburn	
☐ Broken bone: _____	☐ Heavy menstrual problem/Heavy cramping	

Confidentiality Notice:
Reconnect Chiropractic LLC is committed to maintaining and protecting the confidentiality of our patient's personal information. The Notice of Patient Privacy Policy discusses different procedures, polices, and rights of the patient in regards to medical information. If you would like to read a full copy of this notice it is available for your convenience at the front desk. Sign below stating you have been offered a copy of this notice to read.

I have read the above information and certify it to be true and correct to the best of my knowledge and herby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I hereby authorize payment for services rendered to be paid directly to Reconnect Chiropractic. I choose to decline receipt of my clinical summary after every visit.

Patient or Authorized Person Signature: _____ **Date:**_____

Doctor Signature:_____ **Date:**_____