

Patient Information

Name: _____

Date of Birth: _____ Last _____ First _____ Sex: _____ SS#: _____ MI _____

Email address: _____

Mailing Address: _____

Phone # (H) _____ (W) _____ (Cell) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Latino ☐ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

How did you hear about us? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|--|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | | |

Height: _____ Weight: _____ Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain _____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

Do you exercise: ☐ Never ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ **DATE** _____

HISTORY OF PRESENT ILLNESS

Was there an injury or trauma that caused your symptoms? _____

When did your symptoms begin? _____

Where are your symptoms? _____

Describe your symptoms (burning, aching, stabbing, throbbing, shooting, tingling, etc.) _____

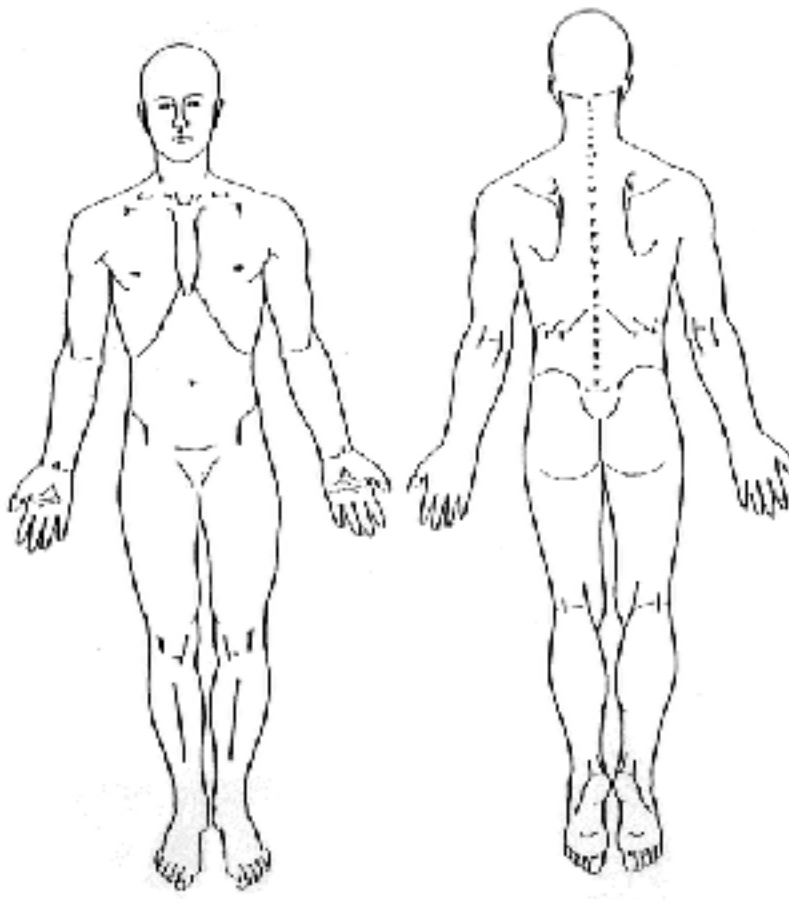
What number would you give your pain? (1 is mild pain and 10 is severe pain) _____

Do you have radiating symptoms (to the arms, legs, or head)? _____

What is the quality of your symptoms (mild, moderate, severe)? _____

Are there any other symptoms associated with this? _____

You may use the diagram below to mark your symptoms



Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, to be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient's Signature

Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care with ChiroMobile, a health history and focused physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of (date) _____ and will expire seven years after the date on which you last received services from us.

Patient Signature _____ Date _____