Confidential Patient Information
(Please Print)

Patient Information — Acct#___________

Dr./Mr./Mrs./Ms./Miss (circle one) — Marital status (circle one) M S W D

Last Name _______ First Name _______ Middle Initial _______ Nick Name _______

Address _______ City _______ State _______ Zip Code _______

Home phone#__________________ Pager#______________ Cell Phone#______________

Email address ____

Social Security No. ______________________ Date of Birth ___________ Sex ☐ M ☐ F

Occupation ______________________________ Employer ______________________

Work address, city, zip ______________________________ Work Phone#___________

Person to contact in an emergency__________________________ Phone#___________

Responsible Party

Name of person responsible for payment of this account______________________

Relationship to patient______________________________ Phone#______________

Address _______ City _______ State _______ Zip Code _______

Insurance Information

If you have any insurance information please provide the staff with your insurance card and or necessary forms.

Symptoms

1. What is your **number one** problem or the **one area** of greatest pain? ____________________________
2. Please rate the level of this pain on the following scale: **0 is no pain, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**
3. When did this problem/pain start?____________________ ☐ Gradual ☐ Sudden ☐ Progressive
4. What do you think caused this problem?______________________________________
5. How often do you experience the pain?
   - _____ 1-2 hours per day
   - _____ About half of the day
   - _____ Most of the day
   - _____ The pain never goes away
6. How would you describe the pain?
   - _____ Dull Ache
   - _____ Sharp/Stabbing
   - _____ Burning
   - _____ Throbbing
   - Other:____
7. What **increases** your pain?____
8. What **decreases** your pain?____
9. Have you ever experienced this problem before? ☐ Y ☐ N When?__________________
10. Is your pain/problem related to other body systems?
    - _____ Bowel/Bladder
    - _____ Numbness/Tingling
    - _____ Muscle Weakness
    - Other:_________________________________
    - _____ No Apparent Relationship

11. List any other complaints currently bothering you and rate your pain level for each.

a. ____________________	0 1 2 3 4 5 6 7 8 9 10
b. ____________________	0 1 2 3 4 5 6 7 8 9 10
c. ____________________	0 1 2 3 4 5 6 7 8 9 10
d. ____________________	0 1 2 3 4 5 6 7 8 9 10

12. Have you ever been involved in an automobile collision? □ Y □ N When? ____________
Were you injured? □ Y □ N Explain ____________
13. Have you ever been injured at work? □ Y □ N When? ____________
Explain ____________
14. List all medications and/or nutritional supplements you are currently taking (prescribed or over the counter)
____
15. List all surgeries you have had (with date) ____________
____

Medical Doctors consulted in the past year:

Name: ____________ Approximate Date of last visit: ____________

Name: ____________ Approximate Date of last visit: ____________

Chiropractic Doctors consulted in the past year:

Name: ____________ Approximate Date of last visit: ____________

Name: ____________ Approximate Date of last visit: ____________

If you have experienced any of the following conditions in the past mark a "**P**" on the line provided. If you are currently experiencing any of the following conditions please mark "**C**" on the line provided. (check all that apply)

__ Alcoholism	__ Convulsions	__ Gout	__ Migraine	__ Rubella
__ Allergies	__ Depression	__ Headaches	__ Miscarriage	__ Scoliosis
__ Anemia	__ Diabetes	__ Heart Attack	__ Multiple Sclerosis	__ Sinus Trouble
__ Arthritis	__ Diarrhea	__ Heart Disease	__ Mumps	__ Stroke
__ Back Pain	__ Ear Infections	__ High Blood Pressure	__ Neck Pain	__ Thyroid Problems
__ Bladder Infections	__ Eczema	__ Irregular Periods	__ Nervousness	__ Tuberculosis
__ Blood Vessel Disease	__ Epilepsy	__ Kidney Disease	__ Neuritis	__ Ulcers
__ Cancer	__ Fainting	__ Low Blood Sugar	__ Pleurisy	__ Uterine Cysts/Tumors
__ Chicken Pox	__ Flat Feet	__ Malaria	__ Pneumonia	__ Venereal Disease
__ Cold Sores	__ Gall Bladder Disease	__ Measles	__ Polio	__ Whooping Cough
__ Constipation	__ Glaucoma	__ Menstrual Cramps	__ Roseola	Other ____________

General Activities and Lifestyle (check all that apply)

__ sleep on waterbed
__ needlepoint/knitting
__ play video games (__________ hrs per day)
__ computer use (__________ hrs per day)
__ read in bed
__ use two or more pillows to sleep with
__ fall asleep in recliner/on couch
__ swim
__ watch television (__________ hrs per day)
__ sewing
__ exercise ______ x/wk
__ sleep on stomach
__ lift weights/wt. mach.
__ jog ______ x/wk

Please add anything else you would like the doctor to know: ____________
____
____

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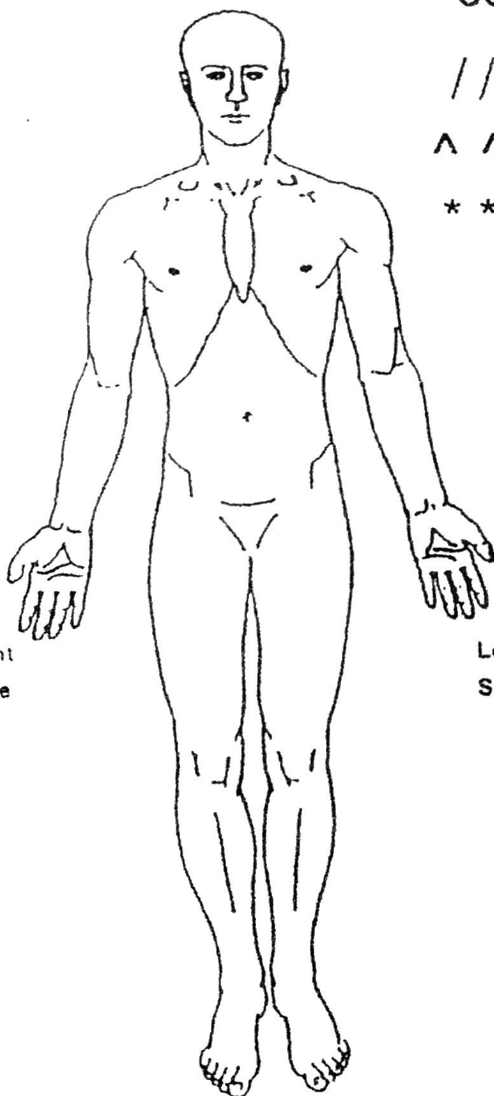
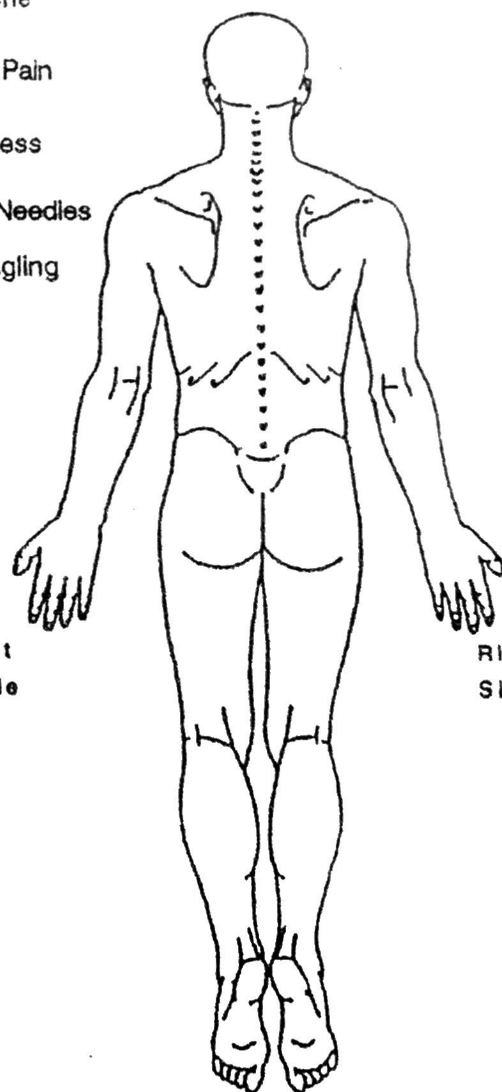
Body Diagram

Acct# ____________

Last Name ______________________________ First Name ______________________________

XXX	Sharp Pain
OOO	Dull Ache
/ / /	Burning Pain
^ ^ ^	Numbness
* * *	Pins & Needles or Tingling





Patient Signature ______________________________ Date ____________

(Signature of parent if the patient is a minor)

Informed Consent For Chiropractic Care

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 this Chiropractic office, a health history and 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 are 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 my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

______________________________	______________________________
Patient Name (printed)	Relationship to patient
______________________________	______________________________
Patient or legal Guardian Signature	Date
______________________________	______________________________
Witness Signature (office staff)	Date