Patient Information

Name ______________________________ Today's Date ______________

Home Address ______________________________ Home Ph. ______________

City ______________ State ____ Zip ________ Work Ph. ______________

Birth date ______________ Age ____ ❑ Male ❑ Female Cell Ph. ______________

Occupation ______________________________ Emer. Contact ______________

Email Address ______________________________ Relationship ______________

Best way to contact you ❑ Home Ph ❑ Work Ph ❑ Cell Ph ❑ Email Emer. Contact Ph. ______________

Marital Status ❑ Single ❑ Married ❑ Other ❑ Separated ❑ Divorced ❑ Widowed

Name / Age of Children ______________________________

Spouse/ Partner Name ______________________________ Contact Ph. ______________

Are you covered by Medicare? ❑ Y ❑ N Medicare # ______________

Please note that we do not accept assignment; payment in full is due at time of service. We will file your paperwork with Medicare.

Is your visit the result of an auto accident? ❑ Y ❑ N *If yes, please download and complete the MVA Questionnaire.*

Ins. Co ______________ **Case** # ______________

Please note that we cannot begin treatment for a personal injury case without an insurance case number.

Have you received chiropractic care before? ❑ Y ❑ N If so, from whom and for how long? ______________

____

What other health care practitioners do you see ?

Name	Type	Phone

How did you find out about us? ______________________________

What things are you not doing because of your health right now? ______________________________

____

How can we help you? ______________________________

____

Thank you!

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Patient Name:

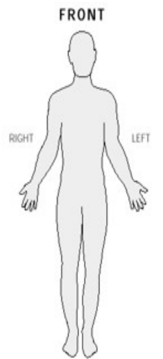
ID #

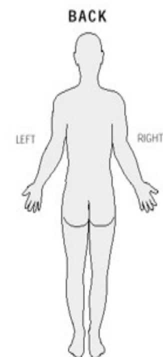
What brings you here today?

Primary Complaint	**Secondary Complaint**	**Other Complaint**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
Experienced before? ❑Yes ❑No	Experienced before? ❑Yes ❑No	Experienced before? ❑Yes ❑No
Chronic problem? ❑Yes ❑No	Chronic problem? ❑Yes ❑No	Chronic problem? ❑Yes ❑No
Getting worse? ❑Yes ❑No	Getting worse? ❑Yes ❑No	Getting worse? ❑Yes ❑No
Due to: ❑Accident ❑Injury	Due to: ❑Accident ❑Injury	Due to: ❑Accident ❑Injury
Date of onset: __________	Date of onset: __________	Date of onset: __________
How it started: __________	How it started: __________	How it started: __________
____________________	____________________	____________________
____________________	____________________	____________________
Worse in ❑AM ❑PM	Worse in ❑AM ❑PM	Worse in ❑AM ❑PM
What relieves it?	What relieves it?	What relieves it?
____________________	____________________	____________________
What makes it worse?	What makes it worse?	What makes it worse?
____________________	____________________	____________________
Prior treatments:	Prior treatments:	Prior treatments:
❑Chiropractic ❑Rx Meds	❑Chiropractic ❑Rx Meds	❑Chiropractic ❑Rx Meds
❑Massage ❑OTC Meds	❑Massage ❑OTC Meds	❑Massage ❑OTC Meds
❑Acupuncture ❑Surgery	❑Acupuncture ❑Surgery	❑Acupuncture ❑Surgery
❑Physical Therapy ❑Ice/Heat	❑Physical Therapy ❑Ice/Heat	❑Physical Therapy ❑Ice/Heat
❑Other: __________	❑Other: __________	❑Other: __________
____________________	____________________	____________________

Please describe your symptoms using these abbreviations.

P = Sharp Pain
D = Dull Pain
B = Burning
T = Tingling





Activities of Daily Living

What effect does your current condition interfere with your daily function?

	None	Mild	Moderate	Severe
Sitting	❑	❑	❑	❑
Getting out of chair	❑	❑	❑	❑
Standing	❑	❑	❑	❑
Walking	❑	❑	❑	❑
Lying down	❑	❑	❑	❑
Bending backward	❑	❑	❑	❑
Bending forward	❑	❑	❑	❑
Climbing stairs	❑	❑	❑	❑
Using a computer	❑	❑	❑	❑
Getting in / out of car	❑	❑	❑	❑
Turning head	❑	❑	❑	❑

	None	Mild	Moderate	Severe
Household chores	❑	❑	❑	❑
Yard work	❑	❑	❑	❑
Reaching overhead	❑	❑	❑	❑
Lifting objects	❑	❑	❑	❑
Showering / bathing	❑	❑	❑	❑
Dressing	❑	❑	❑	❑
Sex life	❑	❑	❑	❑
Falling asleep	❑	❑	❑	❑
Staying asleep	❑	❑	❑	❑
Concentrating	❑	❑	❑	❑
Exercising	❑	❑	❑	❑

Please provide any additional information: ____

____

____

____

MW ____

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Patient Name:

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Review of Systems

Please check any condition that you currently have or have had in the last 12 months ONLY:

Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Angina	❑	❑	Prone to bruising	❑	❑	High blood prs.	❑	❑	High cholesterol
❑	❑	Low blood prs.	❑	❑	Murmur	❑	❑	Poor circulation			

Digestive

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Acid reflux	❑	❑	Anorexia/ bulimia	❑	❑	Bloating	❑	❑	Bloody/ black stool
❑	❑	Constipation	❑	❑	Diarrhea	❑	❑	Food sensitivities	❑	❑	Heartburn

Endocrine

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Fatigue	❑	❑	Frequent infection	❑	❑	Hypoglycemia	❑	❑	Immune disorders
❑	❑	Low energy	❑	❑	Low libido	❑	❑	Swollen glands	❑	❑	Thyroid issues

Females only

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Excessive pain	❑	❑	Hot flashes	❑	❑	Irregular periods	❑	❑	Nipple discharge
❑	❑	PMS symptoms	❑	❑	Vaginal discharge	❑	❑	Date of last period ________________	❑	❑	Date of last gyn exam __________________

Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Bedwetting	❑	❑	Kidney stones	❑	❑	Infertility	❑	❑	Painful urination

General

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Anxiety	❑	❑	Depression	❑	❑	Fainting	❑	❑	Fatigue
❑	❑	Poor appetite	❑	❑	Sudden weight change						

Males only

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Breast lump	❑	❑	Erectile dysfc.	❑	❑	Prostate issues	❑	❑	Sores
❑	❑	Date of last prostate exam ________________									

Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Arthritis (osteo)	❑	❑	Arthritis (rheum)	❑	❑	Elbow/wrist	❑	❑	Foot/ ankle
❑	❑	Hip	❑	❑	Knee	❑	❑	Low back	❑	❑	Mid back
❑	❑	Neck	❑	❑	Osteoporosis	❑	❑	Poor Posture	❑	❑	TMJ
❑	❑	Weakness									

Neurological

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Balance	❑	❑	Dizziness						
❑	❑	Headache	❑	❑	Numbness	❑	❑	Tingling	❑	❑	Tremor

Respiratory

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Allergies	❑	❑	Apnea	❑	❑	Asthma	❑	❑	Emphysema
❑	❑	Hay fever	❑	❑	Pneumonia	❑	❑	Shortness of breath	❑	❑	Sinus problems

Sensory

Had	Have		Had	Have		Had	Have				
❑	❑	Blurred vision	❑	❑	Chronic ear infc.	❑	❑	Hearing loss	❑	❑	Loss of smell
❑	❑	Loss of taste	❑	❑	Ringing in ears						

Skin

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Acne	❑	❑	Eczema	❑	❑	Excessively dry	❑	❑	Hair loss
❑	❑	Psoriasis	❑	❑	Rash	❑	❑	Skin cancer			

MW ____

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Patient Name:

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Medications / Supplements
Please list all medications (Rx and OTC), supplements (vitamins, herbs, minerals, etc) you are currently using or have used in the last 12 months.

Med / Suppl	Rationale	Dosage	Date Started	Prescribing Provider

Please list any adverse reactions to medications, supplements, vaccines and any known food sensitivities.

Please list any past or present exposure to harmful chemicals that you are aware of.

Have you been on antibiotics for a prolonged period?

Type (if known)	Reason	Length of time used

Any household pets or other animals you of other family members are in close contact with?

Please tell us about your birth: ❑ Vaginal delivery ❑ C-section ❑ Forceps / vacuum ❑ Respiratory distress ❑ Other: ______________________

Please indicate the **location of any scars or piercings**.

FRONT

RIGHT LEFT

BACK

LEFT RIGHT

MW ____

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Patient Name: ID #

Lifestyle

Briefly describe what you eat on a typical day. Approximate time:

Breakfast: ________________ ________

Lunch: ________________ ________

Dinner: ________________ ________

Snacks: ________________ ________

Alcohol	❑ Daily	❑ Weekly	Qty ________
Coffee	❑ Daily	❑ Weekly	Qty ________
Tobacco	❑ Daily	❑ Weekly	Qty ________
Sugar	❑ Daily	❑ Weekly	Qty ________
Fast food	❑ Daily	❑ Weekly	Qty ________ What kind?________
Soda	❑ Daily	❑ Weekly	Qty ________ What kind?________
Water	❑ Daily		Qty ________

What are your top two food indulgences? ________________

Does your current state of physical health interfere with your daily life? ❑ Yes ❑ No

Details: ________________

Do you live/work in a damp or moldy home/office? ❑ Yes ❑ No

How much time using a work station? _______ Laptop? _______ Tablet? _______ Smartphone? _______

How much time are you in the car? _______ In front of the tv? _______

Activity level during the week ❑ Sedentary ❑ Light ❑ Moderate ❑ Heavy

Does your current state of physical health interfere with your work activities? ❑ Yes ❑ No

Details: ________________

Please rate your lifestyle health on a scale of 1 (horrible) to 10 (excellent): ________

Reason(s): ________________

Describe your stress level ❑ Low ❑ Moderate ❑ High

Reason(s): ________________

How do you relax or relieve stress? ________________

Please describe your exercise activities:

Type(s): ________________ Frequency: _______ per week/month

Type(s): ________________ Frequency: _______ tper week/month

Activity level on weekends ❑ Sedentary ❑ Light ❑ Moderate ❑ Heavy

Does your current state of physical health interfere with your leisure activities? ❑ Yes ❑ No

Details: ________________

What are your top two summer leisure activities?________________

What are your top two winter leisure activities? ________________

How frequently do you travel: ❑ Annually ❑ Sem--annually ❑ Monthly ❑ Weekly

Describe your sleep pattern: Wake time _______ Bed time _______ Avg hours per night ________

Naps? ❑ Yes ❑ No Frequency: _______

Do you feel: ❑ Rested on awakening ❑ Tired on awakening

Do you: ❑ Awaken during night ❑ Sleep in total darkness

❑ Sleep near an electronic device (ex: smartphone)

Typical sleep position: ❑ Side ❑ Back ❑ Stomach

Mattress Type: ❑ Firm ❑ Soft ❑ Coil ❑ Memory foam / Latex

❑ Adjustable ❑ Other ________________

Pillow Type: ❑ Firm ❑ Soft ❑ Feather ❑ Synthetic ❑ Orthopedic

MW ____

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Patient Name: ID #

Health History

Check any of the following conditions that you currently have or ever had in the past, with the date:

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	AIDS / HIV	❑	❑	Fibromyalgia	❑	❑	Parkinson's Disease
❑	❑	Alcoholism	❑	❑	Fractures	❑	❑	Pneumonia
❑	❑	Allergies	❑	❑	German Measles	❑	❑	Polio
❑	❑	Anemia	❑	❑	Gall Bladder Problems	❑	❑	Prostate Problems
❑	❑	Anorexia / Bulimia	❑	❑	Glaucoma	❑	❑	Prosthesis
❑	❑	Appendicitis	❑	❑	Goiter	❑	❑	Recurrent Headaches
❑	❑	Arthritis	❑	❑	Gout	❑	❑	Rheumatic Fever
❑	❑	Asthma / Hay Fever	❑	❑	Heart Disease	❑	❑	Rheumatoid Arthritis
❑	❑	Bleeding Disorders	❑	❑	Hepatitis	❑	❑	Scarlet Fever
❑	❑	Blood Pressure Problems	❑	❑	Hernia	❑	❑	Scoliosis
❑	❑	Breast Lump	❑	❑	Herpes	❑	❑	Sexual Dysfunction
❑	❑	Bronchitis	❑	❑	High Cholesterol	❑	❑	Sinus Problems
❑	❑	Bursitis	❑	❑	Kidney Infections	❑	❑	Sleep Disorder
❑	❑	Cancer	❑	❑	Kidney Disease	❑	❑	Smallpox
❑	❑	Cataracts	❑	❑	Kidney/Bladder Stones	❑	❑	Stroke
❑	❑	Chemical Dependency	❑	❑	Liver Disease	❑	❑	Suicide Attempt
❑	❑	Chicken Pox	❑	❑	Lung Disease	❑	❑	Thyroid Problems
❑	❑	Chronic Fatigue	❑	❑	Measles	❑	❑	Tonsillitis
❑	❑	Colitis	❑	❑	Migraine Headaches	❑	❑	Tuberculosis
❑	❑	Convulsions	❑	❑	Mononucleosis	❑	❑	Tumor / Growth
❑	❑	Daily Headaches	❑	❑	Multiple Sclerosis	❑	❑	Typhoid Fever
❑	❑	Diabetes	❑	❑	Mumps	❑	❑	Ulcer
❑	❑	Digestive Problems	❑	❑	Muscular Dystrophy	❑	❑	Vaginal Infections
❑	❑	Disc Problems	❑	❑	Osteoporosis	❑	❑	Venereal Disease
❑	❑	Emphysema	❑	❑	Pacemaker	❑	❑	Whooping Cough
❑	❑	Epilepsy				❑	❑	Other ____________________

Injuries/ Operations

Please list any procedures or injuries you have had, with the date:

❑ Appendectomy ______	❑ C-section(s) _________	❑ Concussion __________	❑ Cancer (type) ________________
❑ Gall bladder _________	❑ Fracture/ break ______	❑ Hysterectomy ________	❑ Kidney stones ________________
❑ Knee surgery ________	❑ Pacemaker __________	❑ Pregnancy(s) _________	❑ Shoulder surgery ______________
❑ Sinus surgery ________	❑ Spinal surgery _______	❑ Tonsillectomy ________	❑ Vasectomy ____________________
❑ Whiplash ___________			

Please list any other injuries or operations below:

____

____

____

Family History

Please tell us about the health of your immediate family members:

Relative	Age	Age at death	State of health	Illness
Spouse/partner	________	___________	____________	______________________________
Mother	________	___________	____________	______________________________
Father	________	___________	____________	______________________________
Sister 1	________	___________	____________	______________________________
Sister 2	________	___________	____________	______________________________
Brother 1	________	___________	____________	______________________________
Brother 2	________	___________	____________	______________________________

Please tell us anything else you would like us to know about your family medical history:

____

____

____

MW ____

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Patient Name: ID #

Acknowledgments:

Please read each statement and initial your agreement.

Initials _________ I instruct you to deliver the care that, in your professional judgment, can best help me in the restoration of my health.

Initials _________ I grant permission to be called to confirm or reschedule appointments and to be sent occasional correspondence in the form of cards, email, letters, etc.

Initials _________ I understand that I may request a copy of the HIPAA policy at any time. I understand that it describes how my personal health information is protected and when my information may be released on my behalf.

Initials _________ I understand that x-ray examinations may be indicated as part of my care. I also understand that I have the right to waive an x-ray exam.

Initials _________ I realize that x-ray examinations may be hazardous to an unborn child and certify to the best of my knowledge that I am not pregnant.
Date of last menstrual period: __________ (if applicable)

Initials _________ I acknowledge that my health insurance is a contract between myself and my provider. I understand that any questions I have about my coverage should be directed to my provider.

Initials _________ I understand that payment for all services are due in full at the time services are rendered.

Initials _________ Should my account be referred to an agency or an attorney for collection, I understand that I will be responsible for all collection costs, attorney's fees and court costs.

Initials _________ I understand that arriving 10 minutes past my scheduled appointment time is equivalent to a missed appointment, and I will most likely need to reschedule.

Initials _________ I agree that I am responsible for a $40 missed appointment fee in the event I do not give the required 24 hour notice. I also agree that I am responsible for a $35 returned check fee.

Initials _________ (if applicable) **Consent to evaluate and adjust a minor child:** I, ______________________being the parent or legal guardian of ____ age _______, have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Initials _________ To the best of my knowledge and ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of any of my health concern(s).

____ __________________

Patient or Guardian Signature Date

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