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!

Great River Chiropractic & Whole Body Health

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

_____
_____
_____

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 ____

Patient Name: ID #

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		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 ____

Patient Name:

ID #

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, heavy metals or molds that you know of:

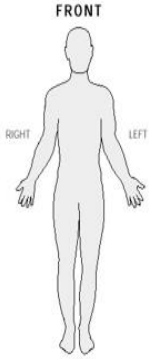
Have you been on antibiotics for a prolonged period?

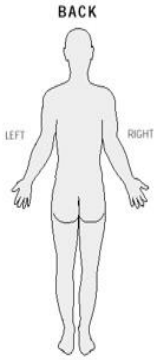
Type (if known)	Reason	Length of time used

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**.





MW ____

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: _____ per 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 ❑ Semi-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: ❑ Have trouble getting to sleep ❑ Awaken during night, once or more? _____

❑ Sleep near an electronic device (ex: smartphone) ❑ Sleep in total darkness

Typical sleep position: ❑ Side ❑ Back ❑ Stomach

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

❑ Adjustable ❑ Other _____

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

MW ____

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: _____
_____	_____	_____

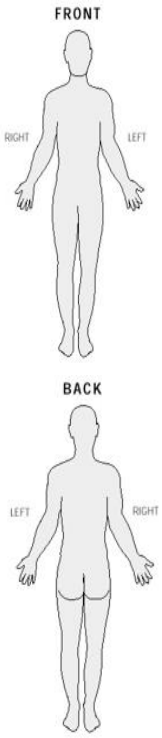
Please describe any musculoskeletal symptoms using these abbreviations.

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		None	Mild	Moderate	Severe
Sitting	❑	❑	❑	❑	Household chores	❑	❑	❑	❑
Getting out of chair	❑	❑	❑	❑	Yard work	❑	❑	❑	❑
Standing	❑	❑	❑	❑	Reaching overhead	❑	❑	❑	❑
Walking	❑	❑	❑	❑	Lifting objects	❑	❑	❑	❑
Lying down	❑	❑	❑	❑	Showering / bathing	❑	❑	❑	❑
Bending backward	❑	❑	❑	❑	Dressing	❑	❑	❑	❑
Bending forward	❑	❑	❑	❑	Sex life	❑	❑	❑	❑
Climbing stairs	❑	❑	❑	❑	Falling asleep	❑	❑	❑	❑
Using a computer	❑	❑	❑	❑	Staying asleep	❑	❑	❑	❑
Getting in / out of car	❑	❑	❑	❑	Concentrating	❑	❑	❑	❑
Turning head	❑	❑	❑	❑	Exercising	❑	❑	❑	❑

Please provide any additional information: _____

_____

_____

_____

MW ____

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 correspondence in the form of cards, email, letters, texts, 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 $25 missed appointment fee in the event I do not give the required 24 hour notice, or a $40 fee if I miss my appointment without 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

MW ____