Personal and Family Health History

Name _____ Date _____
Referred By _____ Social Security # _____
Address_____ City_____ State ____Zip_____
Date of Birth_____ Age_____
Marital Status: S M D W Spouse's Name _____DOB:_____
Phone: (Home) _____ (Mobile) _____
(Work) _____ Is it OK to call you at work? Y N
Employer _____ *Email _____

Insured Party:

Policy Holder:_____ DOB: _____
Relationship to Policy Holder: _____ Employer: _____

Trauma History

List any traumas related to car accidents, sports, hobbies at work and home:
Age 1- 10 _____
Age 10-20 _____
Age 20 to present _____

Health History

Do you smoke? Y N. If yes how many packs per day?_____
Have you ever had surgery? Y N. If yes type and date _____
_____
What medications do you take (prescription and non-prescription)? _____
_____

Current Health Condition

Present complaint (be brief); reason for you visit today _____
Is this condition getting progressively worse? _____
Other doctors seen for this condition _____
Have you seen a chiropractor before? _____

Other Symptoms

❑ Headaches	❑ Neck Pain	❑ Sleeping Problems	❑ Back Pain
❑ Nervousness	❑ Loss of balance	❑ Irritability	❑ Fatigue
❑ Diarrhea	❑ Chest Pains	❑ Neck Stiff	❑ Depression
❑ Finger numbness	❑ Numbness in toes	❑ Shortness of breath	❑ Loss of taste
❑ Light bothers eyes	❑ Loss of memory	❑ Ears ringing	❑ Fever
❑ Fainting	❑ Cold sweats	❑ Loss of Smell	❑ Dizziness
❑ Feet cold	❑ Hands cold	❑ Stomach upset	❑ Constipation

Is there family/personal history of (Circle all that apply): Heart Disease Arthritis
Cancer Diabetes Other Give details: _____
_____

As a result of Chiropractic Care I would like to...**(Please check all that apply)**

- ❑ Feel better quickly
- ❑ Have a healthier spine
- ❑ Live a healthier life
- ❑ Have a healthier life keeping my nerve system healthy.

_____ _____
Signature Date

Chief Complaint Questionnaire

Name:_____ **Date:**_____

What problems are you having? Neck Pain Lower Back Pain Hip Pain

Carpal Tunnel Headaches Shoulder Pain Mid-Back Pain Leg Pain

Rate the average intensity of your symptoms:

Neck____ Midback____ Hips____ Arms____ Low Back____ Hands____

Headaches____ Shoulders____ Feet____ Legs____

None *Unbearable*
1 2 3 4 5 6 7 8 9 10

What treatment have you had for this problem? _____

_____

How long have you been hurting? Days Weeks Months Years

What makes the pain worse? Sitting Standing Walking Lifting Bending

Bright Lights Reading Getting Up Sitting Down Looking Up Laying on Back

Laying on Left/Right Side Turning Driving Sudden Movement

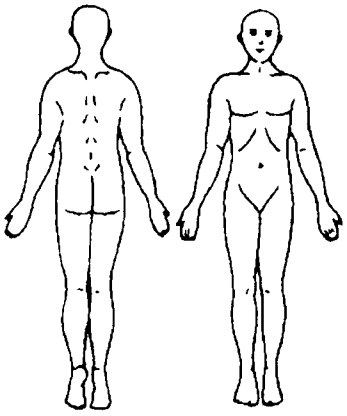
What helps? Heat Ice Medication Resting Massage Walking

Exercising Stretching Ben-Gay Nothing At All

Describe your pain: Sharp Dull Constant Ache Throbbing Shooting

Stabbing Numbness Tingling Tension Tightness

Other:_____



Please outline on the diagram the area of your discomfort

Where does the pain travel? Hands Feet Arms Legs Low Back

Mid-Back Neck Head

Time of Day? Worse in A.M Worse in P.M Worse While Working

Worse during the day All Day, Everyday

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a decrease of the body's ability to express maximum health and function.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate physical irritations from your spinal nervous system. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date