## **ABOUT THE PATIENT**

Name:		Date:		
			State: Zip:	
Home Phone:	Cell Phone:	Work	Phone:	
			(used to send exercises)	
			Male: Female:	
			Children: Ages:	
			State: Zip:	
	Contact Number:			
•	eferring you to our office?			
		proximate Date of Last Visit	1	
Have you seen a Chiropractor before?  Yes No Approximate Date of Last Visit				
			ther health problem list them here.	
		•		
1	How Long?	2	How Long?	
3.	How Long?	4.	How Long?	
	orted this accident to your emp			
	have you reported this injury to	•		
	YOUR HEAL	TH SUMMARY		
Dlease check all sur	nptoms you have ever had, ever		to your current problem	
□ Neck/UB/MB/LB Pain	Shoulder Pain L/R	☐ Heart	☐ Cold/Burning/Itchy	
☐ Headaches/Migraines	☐ Wrist Pain L/R	Palpitation/Murmur	Hands/Feet	
☐ Dizziness	☐ Thyroid Problems	☐ Asthma/Upper Resp.	☐ Pn, Numb, Ting, Wk to	
□ Fever	☐ Depression	Infection	Arms/Legs	
☐ Sinus/Allergies	□ Mood	☐ Heart Burn/Indigestion	<del>-</del>	
☐ Ear Infections	Swings/Irritability	☐ Ulcers/Acid Reflux	Freq. Urination/Urinary	
☐ Ringing/Buzzing in Ears	☐ Fatigue/Sleeping	☐ Stomach/Digestive	Infec.	
☐ Pain Behind	Problems	Problems	☐ Cramping/Irregular	
Eyes/Blurred Vision	☐ Chest Pain/Shortness	☐ Excess Gas	Periods	
☐ Loss of Taste/Smell	of Breath	☐ Cramping in Arms/Legs	Difficulty Getting	
☐ Fainting/Loss of	☐ Cold Sweats/Hot	☐ Sciatica L/R	Pregnant/Impotence	
Balance	Flashes	☐ Hip Pain L/R		
□Nervousness	□Other:			

Please indicate/mark your problem areas on the diagram below:





## **MEDICATIONS I NOW TAKE:**

Please list any medication/supplements you are currently taking:				
HEALTH HABITS:				
Do you smoke? ☐ Yes ☐ Nopacks/day.	Do you drink alcohol? ☐ Yes ☐ Nodrinks/day.			
Do you drink coffee? ☐ Yes ☐ Nocups/day				
	s Supports ☐ Other:			
,				
AWARENESS OF	CHIROPRACTIC PRINCIPLES			
Were you aware that				
◆Doctors of Chiropractic work with the nervous system?	☐ Yes ☐ No			
◆The nervous system controls all bodily functions and system	ns? ☐ Yes ☐ No			
◆Chiropractic is the largest natural healing profession in the	world? □ Yes □ No			
♦If Chiropractic care starts at birth; you can achieve a higher	level of			
health throughout life?	☐ Yes ☐ No			
ABOU	IT MY INSURANCE			
I understand and agree that health and accident insurance p	olicies are an arrangement between an insurance carrier and myself. I			
understand that the Doctor's Office will prepare any necessary	ry reports and forms to assist me in collecting from the insurance			
company and that any amount authorized to be paid directly	to the Doctor's Office will be credited to my account on receipt.			
Insurance CompanyPol	licy Holder Name			
ID # Em	nployer			
Address Inst				
Phone Dat	te of Birth			
Who should receive b	ills for payment on your account?			
☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp ☐ Aut	to Insurance			
<u>Owner</u>	ship of X-Ray Films			
	for X-Rays is for the examination of X-Rays only. The X-Ray negatives			
will remain the property of this office. They are kept on file v	where they may be seen at any time while I am a patient of this office.			
	LS FOR MY CARE			
-	or relief of pain; some go to correct the cause of pain and others for			
correction of whatever is malfunctioning in their bodies. You	r doctor will weigh your needs and desires when recommending your			
care program. Please check the type of care desired so that v	we may be guided by your wishes whenever possible.			
☐ Relief Care – Symptomatic relief of pain or discomfort.				
☐ Corrective Care — Correcting and relieving the cause of the	e problem as well as the symptoms.			
☐ Comprehensive Care — Bring whatever is malfunctioning in	n the body to the highest state of health possible			
with chiropractic care				
	RIZATION FOR CARE			
•	ough the use of adjustments to my spine, as he or she deems			
appropriate.				
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	are charged directly to me and that I am personally responsible for			
	t this office. The doctor will not be held responsible for pre-existing			
	s. I also understand that if I suspend or terminate my care, any fees for			
	due and payable. I hereby authorize assignment of my insurance rights			
and benefits (if applicable) directly to the provider for service	es renuerea.			
Patient Signature Da	ate Guardian/Spouse Signature Date			