

WELCOME

Patient Information

Date: _____

Patient _____ Age _____ Sex: M F

Address _____ Apt. _____ Birthdate _____

City _____ State _____ Zip _____ Patient SS# _____

Home # _____ Work # _____ Ext. _____ E-Mail _____

Single Married Separated Divorced Widowed Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT: Name _____ Relationship _____

Home Phone _____ Work Phone _____ Ext. _____

Whom may we thank for referring you? _____

Work Information

Occupation _____ Phone _____ Ext. _____

Company _____ Address _____

Spouse Information

Name _____ SS# _____ Birthdate _____

Occupation _____ Employer _____

Insurance

Who is responsible for this account? _____ Relationship to patient _____

Insurance Co. _____ Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's name _____ Birthdate _____ SS# _____

Relationship to patient _____ Insurance Co. _____ Group # _____

AUTHORIZATION

I certify that I have read and I understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

X _____ Date _____
Patient's Signature (or parent if a minor)

Current Patient Condition

Reason for visit _____

When did your symptoms appear? _____ Is it getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____

How often do you have this pain? _____ Is it often or does it come and go? _____

Does it interfere with your: Work Sleep Daily routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying down

Health History

Height _____ Weight _____ Number of Children _____

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date started: _____

Date of last physical exam _____ Practitioner name & contact _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis, saliva, bone density):

Outcome _____

What types of therapy have you tried for this problem(s)?

Diet modification Podiatrist Vitamins/minerals Herbs Homeopathy Chiropractic
 Acupuncture Conventional drugs Physical therapy Other _____

Medical: PCP/Internist Orthopedist Neurologist Neurosurgeon Psychiatrist

Date of exam _____ Practitioner name & contact _____

List current health problems for which you are being treated: _____

Current medications (prescription and/or over-the-counter): _____

Major hospitalizations, surgeries, injuries. Please list all procedures, complications (if any) and dates:

<u>Year</u>	<u>Surgery, illness, injury</u>	<u>Outcome</u>

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., job change, family status change, work related, finances, etc.): _____

Do you consider yourself: Underweight Overweight Just right Your weight now: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? Yes No

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (.e.g, fireman, farmer, miner)?

Do you experience any of these general symptoms EVERYDAY?

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Nausea	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Discharge	<input type="checkbox"/> Constipation
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Itching/rash	<input type="checkbox"/> Chronic pain/inflammation

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol - elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins

Other _____

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Surgical menopause
- Menopause
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval between cycles _____ days
- Recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Healthy History

- Arthritis
- Astma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis

Other _____

Other _____

Health Habits

- Tobacco: # per day _____
- Alcohol: _____
- Wine: # glasses/d or wk _____
- Liquor: #oz./d or wk _____
- Beer: # glasses/d or wk _____
- Caffeine: _____
- Coffee: # 6oz. Cup/day _____
- Tea: # 6oz. Cup/day _____
- Soda: # cans/day _____
- Other _____
- Water: # glasses/day _____

Exercise

- 5 - 7 days per week
- 3 - 4 days per week
- 1 - 2 days per week
- 45 min or more duration/wk
- 30 - 45 min duration/workout
- Less than 30 min
- Walk
- Run, Jog, jump rope
- Weight-lift
- Swim
- Box
- Yoga
- Other _____

Nutrition & Diet

- Mixed food diet (animal & veg)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- Total calorie restriction
- Specific food restrictions: _____
- Other _____

Food Frequency

- Servings per day:
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly (hungry or not)
- Eat on the run
- Add salt to food

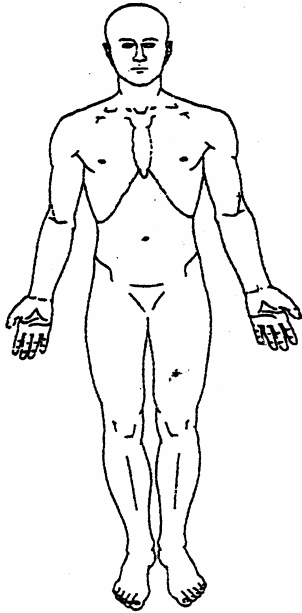
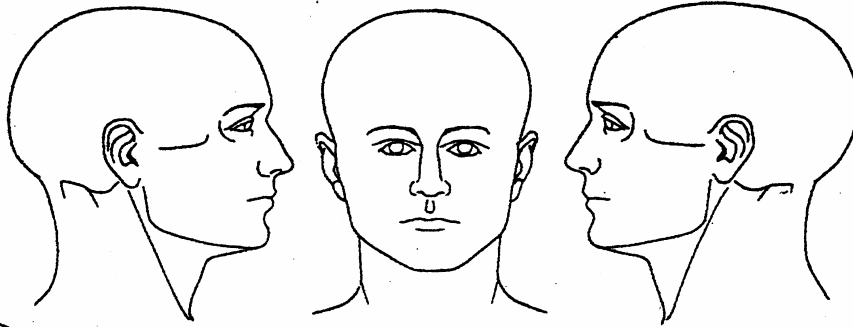
Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (eg, lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (eg. Phytonutrient blends)
- Liquid meals
- Other _____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Feel more motivated
- Be more organized
- Think more clearly; be more focused
- Improve memory
- Do better on tests
- Not be dependent on over-the-counter meds like aspirin, ibuprofen, sleeping aids, etc
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (eg. cancer, heart disease, etc..)

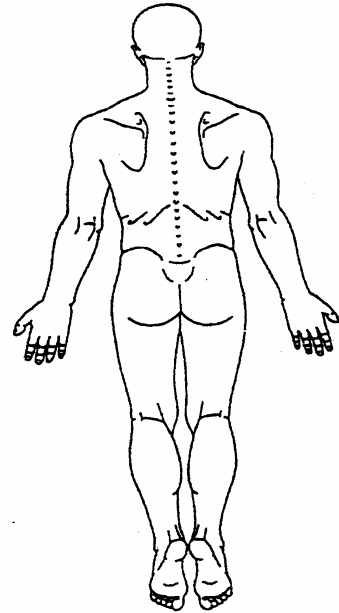
CONFIDENTIAL PATIENT HISTORY



DRAW YOUR PATTERN OF PAIN

Draw the area of most intense pain darkest.

Draw the area of mildest pain lightest.



I verify that all information contained within these pages is true and accurate.

Patient's Signature

Date