

Patient History (Please Print) Date: _____

Name: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Birth Date: _____ Male Female Spouse's Name: _____

Children # _____ Married Single Divorced Widowed Driver's License # _____

Occupation _____ Social Security# : _____

How were you referred to the Office? _____

Have you ever been under chiropractic care before? _____ If yes, when? _____

List your chief complaints in order of severity: Check all those that describe your condition:

Complaint 1: _____ For how long? _____

What originally caused this problem? _____

Sharp Throbbing Shooting Cramps Stiffness Dull Ache Numb/Tingling Burning
 Other: _____

Constant (100%) Frequent (50% - 90%) Intermittent (25% - 50%) Occasional (1% - 25%)

It has been: Getting worse Staying the same Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) 0 1 2 3 4 5 6 7 8 9 10

During the Day it is: Worse in the AM Worse in the PM Stays the same throughout the day

The following **increases** pain:

Moving Sitting Lifting Walking Laying Down Bending Other _____

The following **decreases** the pain:

Moving Sitting Lifting Walking Laying Down Bending Other _____

Does the pain travel/radiate? Yes No If yes, where? _____

Complaint 2: _____ For how long? _____

What originally caused this problem? _____

Sharp Throbbing Shooting Cramps Stiffness Dull Ache Numb/Tingling Burning
 Other: _____

Constant (100%) Frequent (50% - 90%) Intermittent (25% - 50%) Occasional (1% - 25%)

It has been: Getting worse Staying the same Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) 0 1 2 3 4 5 6 7 8 9 10

During the Day it is: Worse in the AM Worse in the PM Stays the same throughout the day

The following **increases** pain:

Moving Sitting Lifting Walking Laying Down Bending Other _____

The following **decreases** the pain:

Moving Sitting Lifting Walking Laying Down Bending Other _____

Does the pain travel/radiate? Yes No If yes, where? _____

Complaint 3: _____ For how long? _____

What originally caused this problem? _____

Sharp Throbbing Shooting Cramps Stiffness Dull Ache Numb/Tingling Burning
 Other: _____

Constant (100%) Frequent (50% - 90%) Intermittent (25% - 50%) Occasional (1% - 25%)

It has been: Getting worse Staying the same Getting better

Pain Scale (0 = No Pain, 10 = Severe Pain) 0 1 2 3 4 5 6 7 8 9 10

During the Day it is: Worse in the AM Worse in the PM Stays the same throughout the day

The following **increases** pain:

Moving Sitting Lifting Walking Laying Down Bending Other _____

The following **decreases** the pain:

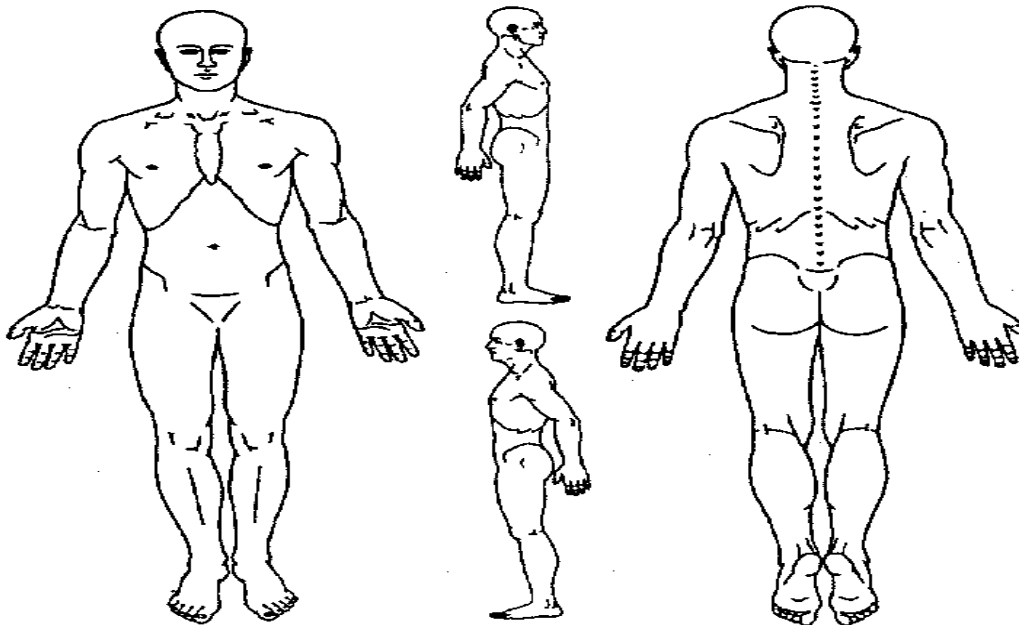
Moving Sitting Lifting Walking Laying Down Bending Other _____

Does the pain travel/radiate? Yes No If yes, where? _____

List other doctors consulted for this condition:

1. _____ Address: _____
2. _____ Address: _____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels.



Does your condition interfere with your:

Work	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Sleep	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Daily Routine	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Recreation	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE

Goals for Care :

Does your condition interfere with any of the following:

<input type="checkbox"/> Computer use	<input type="checkbox"/> Sports	<input type="checkbox"/> Reading	<input type="checkbox"/> Exercise	<input type="checkbox"/> Vacuuming	<input type="checkbox"/> Social Life
<input type="checkbox"/> Cleaning	<input type="checkbox"/> Cooking	<input type="checkbox"/> Watching Kids	<input type="checkbox"/> Yard Work	<input type="checkbox"/> Driving	<input type="checkbox"/> Relationship
<input type="checkbox"/> Shopping	<input type="checkbox"/> Gardening	<input type="checkbox"/> School	<input type="checkbox"/> Self Care	<input type="checkbox"/> Other _____	

Do you suffer from any of the following conditions currently?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abdominal aortic aneurysm | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Alcoholism/Drug Abuse | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Auto immune |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Allergy Shots |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Buzzing/ringing in ears | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Constipation | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Eye Troubles | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hypertension/HBP | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Pain/Tingling/Numbness in arms/legs/hands | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Psychiatric care | |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Throat conditions | <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors/growth | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Unexplained weight gain | <input type="checkbox"/> Unexplained memory loss | <input type="checkbox"/> UTI | |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Ulcers/colitis/IBS | <input type="checkbox"/> Vaginal Infection | <input type="checkbox"/> STI |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Other _____ | | |

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____
Grandparents: _____ Siblings: _____
Other known familial conditions:

For Women only:

Are you Pregnant? Yes No Due Date: _____
Are you Nursing? Yes No Are you taking birth control? Yes No
Do you have regular cycles? Yes No Do you have breast implants?: Yes No
Do you experience painful periods? Yes No

COVID-19 QUESTIONNAIRE:

Have you been vaccinated? _____

If yes, which vaccine did you receive and when? _____

Did you notice any side effects? _____

Have you received any boosters? _____

If yes, which boosters did you receive and when? _____

Did you notice any side effects? _____

Have you had COVID? _____ How many times? _____ When was the last time you had COVID? _____

Have you had any long-term complaints associated with COVID? (please explain) _____

HEALTH HEABITS:

Do you smoke/vape? Yes No Do you drink alcohol? Yes No

Do you eat organic food? Yes No Do you drink soda? Yes No

Do you eat processed food? None Some Moderate

CONCERNS: We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any others that are relevant and **circle your top 3**

- Is it going to hurt? Is it expensive? What do I do if chiropractic does not work?
- Do I have to come forever? Are the X-rays dangerous? What if insurance does not cover chiropractic?
- Can this be fixed? Is it addictive? I don't want to be cracked

STRENGTHS: Strong habits are key to health: It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant and **circle your top 3**

- Stretch 3-5 times a week Exercise 3-5 times a week Drink ½ my body weight of ounces of water
- Take supplements for health Do activities to minimize stress regularly Drink or eat something green everyday
- Have a positive attitude Sleep 6-8 hours a night Get maintenance chiropractic 2-4 x/year
- Pray/meditate Non-smoker Get maintenance chiropractic 4-8x/year

GOALS: We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant **circle your top 3**

- Sleep through the night Continue working/get back to work Play with kids/grandkids normally
- Exercise again Avoid future flare ups Sit/Stand comfortably for an extended period
- Get off pain medications Be ready for an upcoming event Have some moments of relief
- Have a better attitude Additional Goals: _____

People see Chiropractors for a variety of reasons. Some go in for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Type of Care:

- Relief Care: Symptomatic relief of pain or discomfort
- Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

List of previous hospital stays/surgeries (what and when?)

List of any childhood/adult traumas/accidents/falls/auto injuries (what happened and when?)

Is there anything else you think we should know about you or that you would like to discuss (explain)

Authorization for Care and Notice of Privacy

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered. This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception

Patient's Signature: _____ **Date:** _____

Printed Name: _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits risks and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and /or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctors will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual finding, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not usual, however, you may be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects: i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke, which occurs at a rate between once per one million to one per two million.

Other side effects may include healthier lifestyles, more smiling, increased activity, deeper breathing and feeling younger.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Patient's Signature: _____ **Date:** _____

Printed Name: _____