WELCOME TO OUR OFFICE

PLEASE PRINT

Full Name _____ Nickname _____ Date _____
Address _____ Apt. # _____ Age_____ Date of Birth _____/_____/_____
City, State _____ Zip_____ email_____@_____
Home Ph# _____ Work Ph# _____ Cell Ph# _____
Please choose appointment reminder, (you many check more than one) [ ] Text [ ] Voice message [ ] email
Gender: [ ] Female [ ] Male [ ] Transgender [ ] Other _____
Relationship Status: [ ] Married [ ] Partnered [ ] Single [ ] Widowed [ ] Divorced [ ] Separated Number of Children _____
Employer _____ Employers Address _____
Years Employed _____ Job Title _____ Type of Work _____
Partner/Spouse's Name _____ Partner/Spouse's Employer_____
Name of Insurance Company _____ Phone# _____
Are you insured through your spouse partner or parent? Yes No If yes, what is their name ? _____
Their Date of Birth ___/___/___ Employer _____
How will payment be made? [ ] Cash [ ] Check [ ] Credit Card [ ] Workers' Comp [ ] Health Ins. [ ] Medicare [ ] Auto Ins. [ ] Lien
Who should we thank for your referral to our office? _____
Who is your Primary Care Physician? _____ Phone: _____
Address _____ Fax: _____

To help your first visit go smoothly here is what you can expect during approximately the next 45-75 minutes:

1. Paperwork Give your forms to the receptionist when you have completed them. The doctor will use this information to learn about your present health status. **If this visit is regarding an auto accident, a work injury or managed care please let us know, additional forms may be required.** Also take a moment to review and sign our financial policy.

2. Consultation You will meet the doctor, who will review your paperwork and discuss your health history and your present complaint. You will be advised of the cost of any office procedure.

3. Examination A complete examination, including any necessary X-rays, will be performed. Afterwards the doctor will review the results and determine if Chiropractic can help you. When appropriate, you will be referred to other health care professionals.

4. Initial Treatment If you are currently in pain, initial pain relief treatment will begin on your first visit. This may consist of any of the following

Chiropractic Adjustment - The doctor will use a carefully directed and controlled pressure to begin restoring normal motion and position to the moveable bones of your spine. You may feel or hear a slight pop or snap, which is due to joint movement.

Additional Therapy Procedures such as heat, ice, traction, electrical therapy, ultrasound, and diathermy. These procedures are helpful to reduce the pain, spasm, inflammation, or stiffness you may have.

5. Home Therapy The doctor may suggest home use of ice, heat, or stretching exercises, nutritional supplements, and orthopedic supports to reduce your discomfort.

6. Future Visits On your next visit plan to spend 30 - 45 minutes to receive the doctor's report of findings and additional treatment. You are always welcome to bring any family members or friends along so they can learn about your condition.

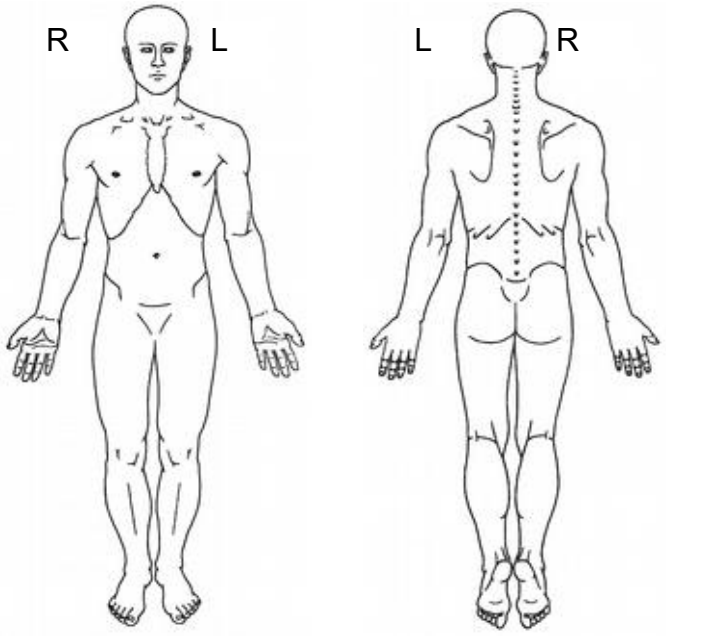
We hope this information will help to make your first visit more pleasant. If you have any questions don't hesitate to ask.
If you were referred by one of our patients let them know we appreciate it.
After you have read this form please initial here. _____

PATIENT HISTORY

Name _____ Date _____

Place the letters on the figure below to indicate the type and location of your present sensations

A= ache **B**= burning **N**= numbness
P= Pins & needles **S**= stabbing **O**= other



Please place a mark on the line below indicating your present level of pain.

No Pain — Worst Pain Imaginable

How often are your complaints present:

0-25% **26-50%** **51-75-%** **76-100%**

Please describe your major complaint with regards to the **type** your pain. For example: dull, sharp, soreness, stiffness, throbbing, shooting, burning, spasm, weakness.

_____

_____

_____

_____

When was the first time you were aware of this problem? _____

On what specific date did the problem progress enough for you to seek treatment today? _____

Did it begin? after a specific injury after multiple incidents gradually over time

Is this condition related to a Work injury Auto accident Slip and fall Sports injury Other _____

How did this condition develop? (What caused it? How did it start? What were you doing when it started?)_____

_____

Since it began, is the pain? Increasing Decreasing Unchanging

What makes your condition better?_____

What makes it worse?_____

Has the condition altered your ability to work, play, or any of your daily activities? Yes No

If yes please explain: _____

_____

What would you like to be able to do now that you can't because of the way you feel? _____

_____

Please turn over and fill out other side

PAST HISTORY

Have you ever had this problem or a similar problem before? Yes No If yes, when and what was the outcome? _____

_____

Did you receive treatment? Yes No If yes, who did you see? _____

Have you consulted a chiropractor in the past? Yes No If yes, who? _____

Dates consulted _____ For what problem? _____

What surgeries have you had in the past? _____

Have you had any previous auto accidents, work or sports injuries? Yes No If yes, please explain _____

_____

PLEASE CHECK OFF ALL PAST OR PRESENT SYMPTOMS

past present **HEAD**
[ ] [ ] Headaches
[ ] [ ] Dizziness
[ ] [ ] Tension
[ ] [ ] Fainting
[ ] [ ] Tired, Fatigue
[ ] [ ] Head feels heavy
[ ] [ ] Light bothers eyes
[ ] [ ] Loss of taste or smell

NECK
[ ] [ ] Neck pain
[ ] [ ] Neck stiffness
[ ] [ ] Neck spasms
[ ] [ ] Popping in neck

SHOULDER
[ ] [ ] Shoulder jt pain (R-L)
[ ] [ ] Tension in shoulders

ARM&HAND
[ ] [ ] Arm pain (R-L)
[ ] [ ] Arm numbness (R-L)
[ ] [ ] Wrist/hand pain (R-L)
[ ] [ ] Weak grip (R-L)
[ ] [ ] Elbow pain (R-L)
[ ] [ ] Cold hands

past present **MID-BACK**
[ ] [ ] Upper back pain
[ ] [ ] Pain between shoulder
[ ] [ ] Rib pain

CHEST
[ ] [ ] Chest pain
[ ] [ ] Shortness of breath
[ ] [ ] Breast pain

ABDOMEN
[ ] [ ] Heartburn
[ ] [ ] Stomach cramps
[ ] [ ] Nervous stomach
[ ] [ ] Food allergies _____
[ ] [ ] Gas
[ ] [ ] Constipation
[ ] [ ] Diarrhea
[ ] [ ] Nausea
[ ] [ ] Vomiting
[ ] [ ] Blood in stool
[ ] [ ] Hepatitis

FAMILY HISTORY
[ ] [ ] Cancer
[ ] [ ] Diabetes
[ ] [ ] Heart Disease
[ ] [ ] Arthritis

past present **LOWER BACK**
[ ] [ ] Lower back pain
[ ] [ ] Buttock pain
[ ] [ ] Muscle spasms
[ ] [ ] Lower back stiffness
[ ] [ ] Back feels tired
[ ] [ ] Pain increased by coughing

HIP,LEG&FOOT
[ ] [ ] Hip pain (R-L)
[ ] [ ] Pain in leg (R-L)
[ ] [ ] Knee pain (R-L)
[ ] [ ] Knee gives way
[ ] [ ] Leg cramps
[ ] [ ] Shooting pain in leg/foot (R-L)
[ ] [ ] Tingling in leg/foot (R-L)
[ ] [ ] Numbness in leg/foot (R-L)
[ ] [ ] Swollen ankles
[ ] [ ] Ankle/Foot pain (R-L)
[ ] [ ] Ankle sprain (R-L)

MISC.
[ ] [ ] Loss of bowel or bladder control
[ ] [ ] Loss of memory
[ ] [ ] Fever
[ ] [ ] Cancer

past present **WOMEN ONLY**
[ ] [ ] Menstrual pain
[ ] [ ] Cramping
[ ] [ ] Irregular cycle
[ ] [ ] Birth control _____type
[ ] [ ] Hysterectomy
[ ] [ ] Caesarean delivery

MEN ONLY
[ ] [ ] Urinary frequency
[ ] [ ] Difficulty starting urination
[ ] [ ] Painful urination

GENERAL
[ ] [ ] Nervousness
[ ] [ ] Irritable
[ ] [ ] Depression
[ ] [ ] Fatigue
[ ] [ ] Loss of sleep____hrs./night
[ ] [ ] Loss of weight ____lbs.
[ ] [ ] Gain of weight ____lbs.
[ ] [ ] Coffee ___cups/day Tea ___cups/day
[ ] [ ] Alcohol ___ drinks per week
[ ] [ ] Pain worse at night or at rest

Are you pregnant? Yes No If yes, what is your due date? _____

Do you smoke? Yes ___ packs per day No If you quit smoking, when? _____

Are you taking any medications? Yes No What kind? _____

Do you take any vitamins or other supplements? Yes No What kind? _____

Do you exercise regularly? Yes No If yes, what type and how often? _____

_____

_____ _____

Patient's Signature **Date**