

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# _____
Marital Status: Married Single Widowed Divorced Separated Number of Children _____
Employer _____ Employers Address _____
Years Employed _____ Job Title _____ Type of Work _____
Spouse's Name _____ Spouse's Employer _____
Name of Insurance Company _____ Phone# _____
Are you insured through your spouse 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. _____

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

- | | | | |
|--|--|---|--|
| <p>past present HEAD</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Tension</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Tired, Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Head feels heavy</p> <p><input type="checkbox"/> <input type="checkbox"/> Light bothers eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of taste or smell</p> <p>NECK</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck spasms</p> <p><input type="checkbox"/> <input type="checkbox"/> Popping in neck</p> <p>SHOULDER</p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulder jt pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Tension in shoulders</p> <p>ARM&HAND</p> <p><input type="checkbox"/> <input type="checkbox"/> Arm pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Arm numbness (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Wrist/hand pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Weak grip (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Elbow pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cold hands</p> | <p>past present MID-BACK</p> <p><input type="checkbox"/> <input type="checkbox"/> Upper back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain between shoulder</p> <p><input type="checkbox"/> <input type="checkbox"/> Rib pain</p> <p>CHEST</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast pain</p> <p>ABDOMEN</p> <p><input type="checkbox"/> <input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> <input type="checkbox"/> Stomach cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervous stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> Food allergies _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Gas</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p>FAMILY HISTORY</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> | <p>past present LOWER BACK</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Buttock pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle spasms</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower back stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Back feels tired</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain increased by coughing</p> <p>HIP,LEG&FOOT</p> <p><input type="checkbox"/> <input type="checkbox"/> Hip pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in leg (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee gives way</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Shooting pain in leg/foot (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Tingling in leg/foot (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness in leg/foot (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle/Foot pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle sprain (R-L)</p> <p>MISC.</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of bowel or bladder control</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of memory</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> | <p>past present WOMEN ONLY</p> <p><input type="checkbox"/> <input type="checkbox"/> Menstrual pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> Birth control _____ type</p> <p><input type="checkbox"/> <input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> <input type="checkbox"/> Caesarean delivery</p> <p>MEN ONLY</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty starting urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p>GENERAL</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Irritable</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of sleep _____ hrs./night</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of weight _____ lbs.</p> <p><input type="checkbox"/> <input type="checkbox"/> Gain of weight _____ lbs.</p> <p><input type="checkbox"/> <input type="checkbox"/> Coffee _____ cups/day Tea _____ cups/day</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol _____ drinks per week</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain worse at night or at rest</p> |
|--|--|---|--|

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