



**Personal Information**

NAME: \_\_\_\_\_ PATIENT #: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
HOME PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_ CELL #: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_ BEST TIME & NO. TO CONTACT: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYER'S NAME & ADDRESS: \_\_\_\_\_  
SINGLE: \_\_\_\_\_ MARRIED: \_\_\_\_\_ DIVORCED: \_\_\_\_\_ WIDOWED: \_\_\_\_\_  
NO. OF CHILDREN: \_\_\_\_\_ NAMES, AGES, GENDER: \_\_\_\_\_  
DO YOU HAVE INSURANCE? YES NO. IF SO, PLEASE GIVE CARD TO OFFICE MANAGER \_\_\_\_\_  
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**Why Chiropractic?**

People go to chiropractors for a variety of reasons and there are different levels of care. Please check the type of care desired so that we may guide you accordingly.

- Stage 1 \_\_\_ Pain Relief: "Just get rid of the pain, Doc!" Relief is short term.
- Stage 2 \_\_\_ Rehabilitation: "Get rid of the pain. But then fix the problem so it doesn't come back"
- Stage 3 \_\_\_ Optimal: "Get rid of the pain, fix the problem, and then put me on preventative maintenance plan- including diet, exercise, stretching, and chiropractic"

Have you received chiropractic care in the past?  No  Yes - if so:

Chiropractor's Name: \_\_\_\_\_ Your experience: \_\_\_\_\_

**Your Health Profile**

List health concerns according to severity	Rate of severity 1=mild 10-bedridden	When did this episode start?	If you had this before, when?	Did problem begin with injury	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

If condition is work or auto accident related - please immediately inform the doctors. If traumatic- please describe \_\_\_\_\_

If you are experiencing pain, is it:  Sharp  Dull ache  Throbbing  
Does the pain travel/radiate anywhere:  No  Yes- please describe \_\_\_\_\_

Since the problem started, it is...  About the same  Getting better  Getting worse

What makes it worse? \_\_\_\_\_

What have you done for this condition that has helped you feel better? \_\_\_\_\_  
\_\_\_\_\_

## Health Profile Continued...

What have you done for this condition that was of no help? \_\_\_\_\_

Is this condition interfering with your:  Work  Leisure  Sleep  Sports/exercise training  
 Positive mental attitude  Hobbies  Other

Other doctors seen for this condition:  Chiropractor  Medical Dr.  Other

Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ What was the diagnosis? \_\_\_\_\_

List any medications you are taking and why: (**prescription** and **non-prescription**) \_\_\_\_\_

Have you had any surgeries? (Surgery/Date): \_\_\_\_\_

Accidents, injuries: (Accident/Date): \_\_\_\_\_

Have you ever had x-rays? (If yes) When: \_\_\_\_\_ Where: \_\_\_\_\_

Area of body: \_\_\_\_\_

Do you wear orthotics or heel lifts?  Yes  No

For women only: Are you pregnant?  Yes  No

## General History

Please list your **top 3 stresses** in each category:

Physical Stress (falls, accidents, work postures):	Biochemical Stress (smoking, unhealthy foods, caffeine poor water intake)	Psychological Stress (work, relationships, finances)
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_____	_____	_____
_____	_____	_____
_____	_____	_____

On a scale of 1-10, ( **1** being very poor and **10** being excellent) describe your:

Eating habits: \_\_\_\_\_ Exercise habits: \_\_\_\_\_ Sleep: \_\_\_\_\_

General Health: \_\_\_\_\_ Mind set: \_\_\_\_\_ Goal setting: \_\_\_\_\_

Please **circle** all symptoms and conditions you have **ever** had:

### General

Allergies  
Sinus problems  
Frequent colds/flu  
Frequent sore throat  
Frequent coughs/hoarse  
Ear aches  
Dental Problems  
Gums bleed easily  
Skin Problems  
Bruise Easily  
Emotional Stress  
Irritability  
Nervousness  
Loss/Problems with Sleep

### Urinary

Bladder Trouble  
Excessive/Painful Urination  
Discolored Urine

### Nervous System

Tingling in arms/legs  
Numbness  
Dizziness/Fainting  
Forgetfulness/Confusion  
Depression  
Epilepsy

### Musculoskeletal

Headaches  
Neck pain  
Shoulder/rotator cuff pain  
Pain between shoulders  
Low back pain  
Joint pain/Stiffness

### Digestion

Poor/Increased Appetite  
Irregular Bowel Movement  
Excessive Thirst

Nausea/ Vomiting  
Diarrhea/ Constipation  
Hemorrhoids  
Liver/Gall Bladder Problems  
Weight Gain/Loss  
Abdominal Cramps  
Gas/Bloating  
Heartburn/ Ingestion  
Black/ Bloody Stool  
Colitis  
Difficulty Swallowing  
Burping/Belching

### Jaw

Pain/ Clicks/ Pops  
Grinding Teeth  
Jaw Clenching

### Female

Premenstrual Symptoms  
Breast Pain/ Lumps  
Hot Flashes  
Menopause symptoms

### Male

Loss of Sex Drive  
Prostate Troubles

### Heart Problems

Chest Pain/ Short of Breath  
Lung Problem/ Congestion  
Heartbeat Irregularities  
Heart Problems  
High Blood Pressure  
High Cholesterol  
Varicose/ Ankle Swelling  
Anemia

## Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health conditions or concerns they may have:

Children: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Brothers: \_\_\_\_\_  
Sisters: \_\_\_\_\_  
Horses/Dogs/Cats: (Smile, you are almost done!) \_\_\_\_\_

## Informed Consent to Examination, Chiropractic Care, and Adjustments

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including physical therapy and diagnostic x-rays on me (or the patients named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic that are associated by the above named doctor.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to fractures, disc injuries, dislocations, and sprains. I do not expect the doctor to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for any present condition and for any future condition(s) for which I seek treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*If we missed any other pertinent information about your case to help you towards optimal health, please let us know here:

Thank you for filling out this form, it is your first step to **Creating Wellness!** Return this to our staff and someone will be right with you!