Dear New Patient,

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for you and your family.

PERSONAL INFORMATION

Today's Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Social Security Number: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ ☐ Left Handed ☐ Right Handed

Address: _____

City: _____ State _____ Zip Code: _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Employer: _____ Occupation: _____

Marital Status: ☐ M ☐ W ☐ D ☐ S Spouse's Name: _____

Children's Names and Ages: _____

Who referred you to our office, or how did you hear about us? _____

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years	Yes	No	Unsure	Comments (if any)
Did you have any childhood illnesses?	☐	☐	☐	_____
Were you vaccinated?	☐	☐	☐	_____
Did you have any falls from a height over 3 feet? (i.e. crib, bunk bed, trees)	☐	☐	☐	_____
Did you play youth sports?	☐	☐	☐	_____
Did you take/use any drugs?	☐	☐	☐	_____
Was there any prolonged use of medicine's such as antibiotics or an inhaler?	☐	☐	☐	_____
Were you involved in any car accidents?	☐	☐	☐	_____
Did you suffer any form of abuse?	☐	☐	☐	_____
Were you under regular chiropractic care?	☐	☐	☐	_____
Adulthood – (18 to present)				
Do / did you smoke?	☐	☐	☐	_____
Do / did you drink alcohol?	☐	☐	☐	_____
Have you been in any accidents?	☐	☐	☐	_____
Do / did you play adult / extreme sports?	☐	☐	☐	_____

On a scale of 1-10 describe your level of stress (1 = none / 10 = extreme) Occupational _____ Personal _____

Which answer best describes your own current ideas and values toward health?

☐ TREATMENT ONLY – I only consult a doctor when I have problems/symptoms and discontinue as soon as the symptoms leave.
☐ EARLY DETECTION – In addition to symptom relief, I see dr.'s occasionally to detect problems early before they become serious.
☐ PREVENTION – I'm conscious about my health, diet, exercise and actively pursue these because I feel and perform better.
☐ WELLNESS – I actively inform myself about true health and I am concerned with the long-term effects of things on my health.

Have you ever:

Bought bottled water: ☐ Yes ☐ No
Joined a health club: ☐ Yes ☐ No
Consumed vitamins or supplements: ☐ Yes ☐ No

To help us better explain chiropractic as it applies to your health and life and how we may be able to help you, please check the one best answer for each statement below:

1) I remember important things in my life by what I… ☐ See ☐ Hear ☐ Feel
2) The primary reason I brush my teeth is to… ☐ Avoid tooth decay and gum disease ☐ Make sure I have healthy teeth and gums
3) When I make decisions I generally… ☐ Gather the facts and weigh the evidence ☐ Make the right choice instantly
☐ Consult my friends and family ☐ Depends on how I feel about it

Each of us must balance a variety of demands on our time, money and emotions. Please rate the following items, in order, relative to their importance to you with a (1) being the most important and (7) being the least important.

____ Marriage ____ Automobile ____ Job ____ Health ____ House ____ Kids ____ Pet

Addressing the Issues that Brought you to the Office

Briefly describe your main concern. *If you're here for wellness care please go to #11* _____

1) If you are experiencing a symptom, is it… (check more than one if necessary to describe your problem)

☐ Sharp ☐ Dull ☐ Burning ☐ Numbness & Tingling ☐ Pressure ☐ Comes & Goes ☐ Travels ☐ Constant
☐ Other: List _____

2) Where is the symptom? _____

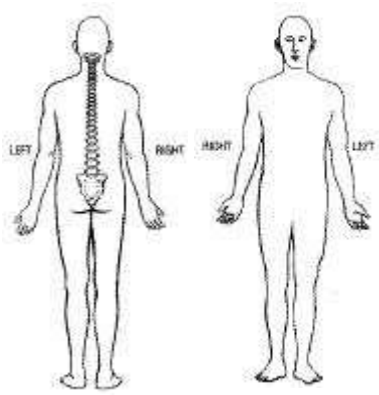
3) When did the *symptom* first start? _____

4) Since the symptom started, it is…

☐ About the same ☐ Getting Better ☐ Getting Worse

5) What makes it worse: _____

What times of day are the symptoms worse: _____



6) Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

7) Does this cause you to be: ☐ Irritable ☐ Moody ☐ Worried

8) Is your Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Physical Illness ☐ Emotional Illness ☐ Chemical Exposure ☐ Pregnancy/Childbirth

Please outline on the diagram the area of your discomfort.

9) Other Doctors seen for this problem and when (please list):

☐ Chiropractor _____ ☐ Medical Doctor _____ ☐ Other _____

10) Drugs you now take: ☐ Over-the-Counter Pain Relievers ☐ Prescription Pain Medications ☐ Muscle Relaxer ☐ Blood Pressure Medicine ☐ Insulin ☐ Other _____ ☐ None

11) Past Surgeries / Operations _____

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pin & needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins & needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Upset stomach
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐Cold sweats	☐ Lights bother eyes	☐ Problems Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers
☐ Sinus Problems	☐ Allergies	☐ Asthma	

12) Personal Care: You use the following on a regular basis:

☐ Hair Spray ☐ Cologne ☐ Perfume ☐ Deodorant ☐ Antiperspirant ☐ Cosmetics
☐ Eye Drops ☐ Scented Soap / Detergent ☐ Dryer Fabric Scent ☐ Fluoridated Products ☐ Ammonia
☐ Clorox

13) You do the following on a regular basis:

☐ Jog ☐ Run ☐ Swim ☐ Walk ☐ Bicycle ☐ Garden ☐ Yoga ☐ Meditation ☐ Breathing Exercises
☐ Aerobics ☐ Weight Training

14) Do you have strong cravings for particular foods? List _____

_____ **Are there foods you avoid:** _____

15) Dietary Intake:

Breakfast Yesterday: _____

Lunch Yesterday: _____

Snacks Yesterday: _____

Dinner Yesterday: _____

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 mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother/Father _____

Siblings _____

Others _____

FEMALE ONLY: Is there any chance that you may be pregnant? ☐ Yes ☐ No

---

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. The doctor's office may bill my insurance as a courtesy to me and will prepare any necessary reports and forms (fees may apply) to assist in making collection from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand and agree that if I suspend or terminate care, any fees for services rendered to me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of but not limited to, spinal adjustments. It is understood and agreed the amount paid the doctor is for the examination and reading of x-rays only. The x-rays will remain property of this office, being on file where they may be seen at any time while a client of this office. The client also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Client's Signature _____ Date _____

Doctor's Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____