

Personal Information



Name _____ Birth Date ____/____/____ Age: _____ Sex _____ Date _____
 Address _____ City/State/Zip _____
 Day Phone _____ Social Security# _____ E-mail _____
 Evening Phone _____ Employer _____ Occupation _____
 Circle One: Single | Married | Widowed | Divorced Spouse's Name _____
 Health Insurance _____ Name & D.O.B of insured _____
 Who may we thank for referring you to our office? _____

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
Did you have any childhood illnesses?	_____	_____	_____	_____
Where you vaccinated?	_____	_____	_____	_____
Did you have any major falls?	_____	_____	_____	_____
Did you play youth sports?	_____	_____	_____	_____
Did you take/use any drugs?	_____	_____	_____	_____
Was there any prolonged use of medicine? (such as antibiotics or inhaler)	_____	_____	_____	_____
Where you involved in any car accidents?	_____	_____	_____	_____
Did you suffer from any form of abuse?	_____	_____	_____	_____
Were you under regular chiropractic care?	_____	_____	_____	_____

Adulthood (age 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 consult a doctor if I have a problem/symptom and discontinue as soon as the symptom leaves.
- 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 & perform better.
- WELLNESS - I actively inform myself about health and am concerned with the long-term effect of things on my health.

Have you ever:

Bought bottled water: Yes ___ No ___ Joined a health club: Yes ___ No ___ Consumed vitamins/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
- 3) When I make decisions, I generally: ___gather all the facts and weigh the evidence ___make the right choice
 ___consult my family/friends ___depends on how I fell 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 ___God/Spirituality ___House ___Kids

Addressing The Issues That Brought You To Our 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 all that apply)

Sharp Dull Burning Numbness & Tingling Pressure Comes & goes Constant Travels

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 worst? _____

6) What makes it better? _____

7) Yes, It interferes with my: Work Sleep Walking Sitting Hobbies Leisure

8) It causes me to be: Irritable Moody Worried Anxious Fearful

9) Is your condition: Work related Auto accident Home injury None of these

10) Other Doctors seen for this problem and when:

Chiropractic Doctor _____

Medical Doctor _____

Other _____

11) Drugs you now take: Over the counter pain relievers Prescription pain medications

Prescription muscle relaxer Blood pressure medicine Insulin Other _____ None

12) Past Surgeries: _____

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

Headaches

Pins and needles in legs

Fainting

Neck Pain

Loss of smell

Pins and needles in arms

Back pain

Loss of balance

Loss of taste

Buzzing in ears

Ringing in ears

Dizziness

Nervousness

Numbness in fingers

Numbness in toes

Stomach upset

Fatigue

Depression

Irritability

Tension

Sleeping problems

Neck stiffness

Cold hands

Cold feet

Diarrhea

Constipation

Fever

Hot flashes

Cold sweats

Light bothers eyes

Problems urinating

Heartburn/reflux

Mood swings

Menstrual pain

Menstrual irregular

Ulcers

Sinus problems

Allergies

Asthma

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 myself. 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 authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

I hereby authorize the doctor to treat my condition, as he 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 readings of x-ray only. The x-rays will remain the property of this office, being on file where they may be seen at any reasonable 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.

Patients Signature _____ Date _____