



Patient History (page 1 of 2)

Name _____ Referred by _____
 Date _____ Social Security # _____
 Address _____ Occupation _____
 City, State, Zip _____ Employer _____
 Phone (H) _____ (W) _____ Marital Status S M D W
 E-mail _____ Spouse's Name _____
 Date of Birth _____ (AGE) _____ Spouse's Date of Birth _____
 Family Medical Doctor: _____ *When doctors work together it benefits you.*
 May we have your permission to update your medical doctor regarding your care at this office? Yes No

CHILDREN

PREVIOUS CHIROPRACTIC CARE?

Name _____	Age _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason _____
Name _____	Age _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason _____
Name _____	Age _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason _____
Name _____	Age _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason _____

HEALTH INSURANCE

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Medicaid Medicare Auto Accident Workers Compensation
 Medical Savings Account & Flex Plans Other _____

Please provide us with your insurance card when you submit your patient history form.

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, health care operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

I attest that all of the above and following information on this form is correct to the best of my knowledge.

Patient's Signature _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

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CIRCLE ALL THAT APPLY

PATIENT SPOUSE CHILD 1 CHILD 2 CHILD 3 STAFF COMMENTS

Labor and Birth

Forceps or Vacuum Birth?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach / Cephalic?	Y	Y	Y	Y	Y	_____
Induced labor?	Y	Y	Y	Y	Y	_____

Did or do you...

Smoke?	Y	Y	Y	Y	Y	_____
Drink?	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or non-prescriptive)	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have accident, work, or sports injuries?	Y	Y	Y	Y	Y	_____

CURRENT HEALTH CONDITION

Briefly tell us the reason for your visit today: _____

Pain or Problem started on _____ Pain is: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with Work? Sleep? Other: _____ Is it getting worse? Yes No

Other Doctors seen for this condition _____

Any home remedies? _____ Are you currently pregnant? Yes No

OTHER SYMPTOMS

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tension | <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Ears ring | <input type="checkbox"/> Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> Buzzing in ear |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Hands cold | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Other _____ | | | |

Are you currently under drug and medical care? _____

What medications are you taking? _____ How Long? _____

Have you had surgery? Yes No What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

HISTORY OF	HEART DISEASE	STROKE	ARTHRITIS	CANCER	DIABETES	OTHER
Mother's Side	Y	Y	Y	Y	Y	_____
Fathers Side	Y	Y	Y	Y	Y	_____

As a result of my chiropractic care, I would like to (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier spine |
| <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy | <input type="checkbox"/> Live a healthier lifestyle |



Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Each patient must understand both the objective and the method that will be used to attain it.

ADJUSTMENT *The adjustment is the specific application of forces that facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.*

VERTEBRAL SUBLUXATION *A misalignment of one or more of the 24 vertebra in the spinal column which causes a decrease in nerve function and alters the transmission of brain impulses. Gone untreated, subluxations result in a lessening of the body's innate ability to achieve its maximum health potential.*

HEALTH *The state of physical, mental and social well being, not just the absence of disease or infirmity.*

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise the patient. If the patient requires specific diagnosis or treatment of those findings, we will recommend that they seek the services of another health care provider who specializes in that area.

Our only objective is to eliminate the interference that hinders the body's innate ability to achieve maximum health. Our method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(signature)

(date)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive an initial chiropractic examination.