

GENERAL INFORMATION

Name: _____ Preferred Name: _____ Date: _____
 Address: _____
 City / Prov. / Postal Code: _____
 Home #: _____ Cell #: _____ Work #: _____
 E-Mail Address: _____
 Would you like to receive e-mail appointment reminders? [] Day Of The Appointment [] 1 Day Before
 Birthday (MM/DD/YR): _____ Age: _____ Gender: M or F
 Occupation: _____ Employer: _____
 Marital Status: S D W M Spouse / Partner's Name: _____
 Children's Name(s) and Ages: _____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? ___ Yes ___ No Date of last visit: _____
 Name of last chiropractor: _____
 Reason for seeing them: _____
 Describe your experience? _____
 How frequently did you go for adjustments? _____
 What made you decide not to return to see them? _____

Who may we thank for referring you to our office? /or/ How did you choose us?

- | | |
|--|---|
| <input type="checkbox"/> Family/ Friend (name) _____ | <input type="checkbox"/> Workshop (which group) _____ |
| <input type="checkbox"/> Farmer's Market | <input type="checkbox"/> Walk-in |
| <input type="checkbox"/> Health Care Provider _____ | <input type="checkbox"/> Print Advertisement _____ |
| <input type="checkbox"/> Website | <input type="checkbox"/> Other _____ |

What are your health goals: ___ Symptom Relief ___ Wellness Care ___ 100% Health Potential!

Do you feel that you are healthier today than you were 1 year ago? ___YES ___NO

By continuing your current lifestyle choices, do you feel that you will be in better health or worse health 5 years from now? ___Better ___Worse

Why do you want help with your health? _____

IMPORTANT NOTE:

Today's visit will be focusing on assessing the health of your **spine and nervous system**. Your central nervous system (brain and spinal cord) is the master controller of your body. Everything in your life is processed and controlled by your nervous system, therefore **your health and overall quality of life is dependent on proper function and communication**. Due to the close relationship with your spine, if your spine is misaligned and degenerating, it can interfere and alter the function of your nervous system (**subluxation**). The result of this miscommunication between your brain and body in some cases is pain or discomfort but it can have broader, more serious effects such as energy loss, fatigue, depression, immune problems, digestive problems, high blood pressure and many more. Many times, **subluxations are affecting your health long before symptoms show up**. By continuing to fill out this form, we will understand how subluxations may already be affecting your health and quality of life.

HEALTH CONCERN – FILL IN ALL AREAS

Please check (✓) all that you have experienced in the last 12 months

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Rib Pain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Allergies | <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Knee/Ankle Pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Hip Pain | |

Which condition brought you to our office? _____

On a scale of 1–10 (10 being severe), how bad is the problem? _____ / 10

When did it start? _____ How? _____

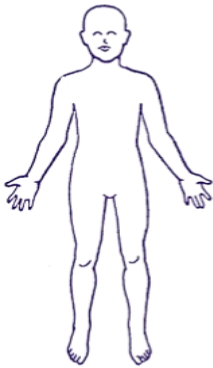
Is it ___ getting better ___ getting worse ___ staying the same?

How would you describe the problem? _____

Are you taking medication for this condition? ___ No ___ Yes Please List: _____

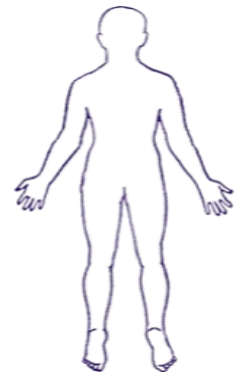
Please list ALL other medications you are currently taking **and for what reasons:**

Where is the problem? Please circle or draw on the illustrations and explain or describe your present condition in the lines below (i.e. sharp, dull, burning, tight, throbbing...).



Front _____

Back _____



What makes it worse? _____

What makes it better? _____

What parts of your life is this condition interfering with: ___ Work ___ Leisure ___ Sleep

___ Exercise ___ Positive mental attitude ___ Hobbies ___ Other _____

Fill out ALL detail below for the NEXT 3 MOST CONCERNING CONDITIONS that you checked off at top of this page:

Condition 1: _____

On a scale of 1–10 (10 being severe), how bad is the problem? _____ / 10

When did it start? _____ How? _____

Is it ___ getting better ___ getting worse ___ staying the same?

How would you describe the problem? _____

Are you taking medication for this condition? ___ No ___ Yes Please List: _____

Condition 2: _____

On a scale of 1-10 (10 being severe), how bad is the problem? _____ / 10

When did it start? _____ How? _____

Is it ___ getting better ___ getting worse ___ staying the same?

How would you describe the problem? _____

Are you taking medication for this condition? ___ No ___ Yes Please List: _____

Condition 3: _____

On a scale of 1-10 (10 being severe), how bad is the problem? _____ / 10

When did it start? _____ How? _____

Is it ___ getting better ___ getting worse ___ staying the same?

How would you describe the problem? _____

Are you taking medication for this condition? ___ No ___ Yes Please List: _____

Your Injury/ Surgery History

Have you had any surgery? (Please include all surgeries)

1. Type: _____ Date: _____

2. Type: _____ Date: _____

3. Type: _____ Date: _____

Accidents and / or injuries: auto, work related or other (especially those related to your present problems).

1. Type: _____ Date: _____ Hospitalized: ___ Yes ___ No

2. Type: _____ Date: _____ Hospitalized: ___ Yes ___ No

3. Type: _____ Date: _____ Hospitalized: ___ Yes ___ No

Your Informed Consent



Chiropractic care has been proven to be safe, both clinically and scientifically. The risk of injuries and complication is so small that Chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few "side effects" associated with it and we feel that it is responsible to let you know:

- A. Research shows that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.
- B. While extremely rare, there have been reports of ligament sprains and rib fractures.

I have read and understand the above consent. If I have any questions or concerns, I will discuss them with my Chiropractor.

I understand that research is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes. (Your full name will not be used).

I consent to the care recommended by my Chiropractor and extend this consent to include all other Chiropractors in this office.

Your name: _____ Date: _____

Signature: _____

Witness: _____