

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Email: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Male Female

Marital Status: Married Single Divorced Separated Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Mail Clinic Location Other _____

Payment for Services will be by: Cash Check Credit Card Health Insurance

Automobile Insurance

Name of Insurance Co.: _____ Insured's Employer: _____

Employer's Phone #: _____

Insured's Date of Birth: _____

Are you covered by more than one insurance company? Yes No Name _____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? Yes No

ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____

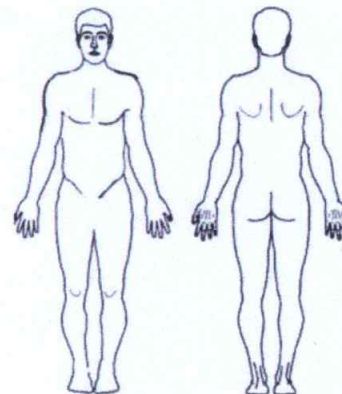
Job Auto Other 2. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

Rate them on a scale of 1-10, with 10 being the worst. Then mark an "X" on the picture where you have pain.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Rate 1-10



SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT
ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____ SYMPTOMS
HAVE PERSISTED FOR # ___ HOUR(S) ___ DAY(S) ___ WEEK(S) ___ MONTH(S) ___ YEAR(S)
SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU PREGNANT NO YES

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion constipation
depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever head seems too heavy
headaches insomnia light bothers eyes loss of balance loss of smell loss of taste low resistance to colds
muscle jerking numbness in fingers numbness in toes pins and needles in arms pins and needles in legs
ringing in ears shortness of breath stiff neck stomach upset

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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal columns which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Patient's Signature: _____ Date: _____