Current Health

What Are Your Pressing Health Concerns? _____

_____

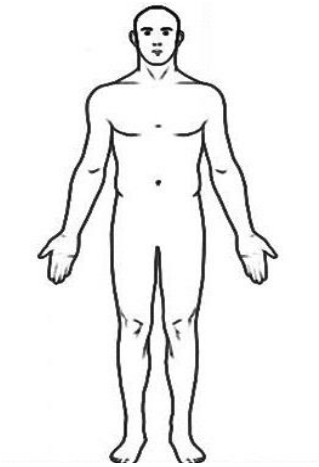
_____

How Long Have These Concerns Been An Issue For You? _____

Are These Issues… ☐Intermittent ☐Occasional ☐Frequent ☐Constant

☐Getting Worse ☐Improving

Where Are These Issues Located? (Please Use Diagrams Below To Explain)



☐Front _____

_____

_____

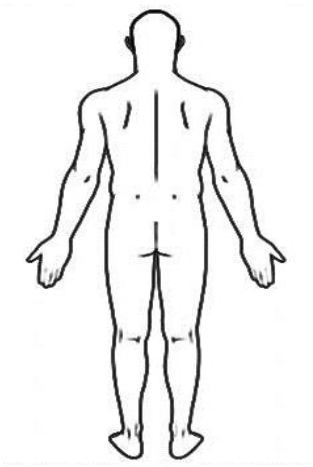
_____

☐Back _____

_____

_____

_____



Do You Experience (Check All That Apply) ☐Pain ☐Numbness ☐Tingling ☐Aches

Is Your Pain (Check All That Apply) ☐Sharp ☐Dull ☐Throbbing ☐Constant ☐Intermittent

Are Your Symptoms Affected By (Check All That Apply) ☐Sitting ☐Standing ☐Walking

☐Bending ☐Lying Down ☐Weather ☐Other _____

Please Explain _____

_____

Do You Feel ☐Cramps ☐Burning ☐Stiffness ☐Swelling ☐Other _____

Please Explain _____

_____

Do Your Symptoms Interfere With ☐Work ☐Sleep ☐Day To Day Activities ☐Sports ☐Other

Please Explain_____

_____

On A Scale From One To Ten (One Being Least and Ten Being Most), Please Rate The Severity Of Your Symptoms… (Circle) 1 2 3 4 5 6 7 8 9 10

Health History

Do You Have Or Have You Had Any Of The Following? (Please Check All That Apply)

☐Pneumonia	☐Mumps	☐Influenza	☐Rheumatic Fever	☐Smallpox
☐Pleurisy	☐Polio	☐Chicken Pox	☐Thyroid Disease	☐Diabetes
☐Epilepsy	☐Cancer	☐Depression	☐Whooping Cough	☐Anemia
☐Eczema	☐Measles	☐Arthritis	☐Heart Disease	☐Rashes
☐Colitis	☐Stroke	☐Allergies		

Have You Ever Been Diagnosed With A Condition Or Illness Not Mentioned Above? ☐Yes ☐No

If Yes, Please List _____

Do You Drink (Check All That Apply) ☐Coffee ☐Tea ☐Alcohol ☐Caffeinated Soda ☐Diet Soda

Do You Use (Check All That Apply) ☐Cigarettes ☐Recreational Drugs ☐Artificial Sweeteners ☐ Sugar

Have You Ever Suffered From Any Of The Following (Check All That Apply)?

☐Neck Pain	☐Difficulty Breathing	☐Discolored Urine
☐Low back Pain	☐Stuffy Nose	☐Gas/Bloating After Meals
☐Headache	☐Fainting	☐Heartburn
☐Migraine	☐Weight Loss	☐Irritable Bowel
☐Arm Pain/Tingling	☐Poor Appetite	☐Black or Bloody Stools
☐Shoulder Pain	☐Excessive Appetite	☐Constipation
☐Hand Pain/Tingling	☐Nervousness	☐Hemorrhoids
☐Leg Pain/Tingling	☐Confusion	☐Liver Problems
☐Jaw Pain	☐Depression	☐Paralysis
☐Chest Pain	☐Dental Problems	☐Numbness
☐Lung Problems	☐Excessive Thirst	☐Fatigue
☐Heart Problems	☐Frequent Nausea	☐Dizziness
☐Abnormal Blood Pressure	☐Prostate Problem	☐Loss Of Sleep
☐Irregular Heartbeat	☐Breast Pain/Lump	☐Difficulty Hearing
☐Ankle Swelling	☐Cramps	☐Ear Pain
☐Cold Extremities	☐Painful Urination	☐Blurred Vision
☐Bladder Trouble	☐Vision Problems	☐Excessive Urination

Please List Any Condition You Experience Not Mentioned Above _____

If Applicable, Tell Us The Date Of Your Last Menstrual Period _____

Please List Past Injuries That You Have Experienced (Check All That Apply)

☐Falls/Accidents	☐Head Injuries	☐Fights
☐Sports Injuries	☐Broken Bones	☐Dislocations
☐Knocked Unconscious	☐Traction	☐Surgery
☐Extensive Dental Work	☐Dental Applications	☐Spinal Tap
☐Used or Use a Cane or Walker	☐Other:_____	

If Yes to Any Of The Above, Please Describe _____

What Do You Know About Chiropractic Care?

In Your Own Words, What Do Chiropractors Do? _____

_____

Do Any Of Your Friends Or Relatives Receive Care From A Chiropractor? ☐Yes ☐No

If Yes, Do They Use Chiropractic Care For Any Of The Following?

☐Health Maintenance/Optimization ☐Health Problems ☐Both

Are You Seeking Chiropractic Care For Any Of The Following?

☐Health Maintenance/Optimization ☐Health Problems ☐Both

What Would You Like To Gain From Chiropractic Care? _____

_____

Are There Other Health Concerns Or Anything Else That You Would Like Us To Know About You? ☐Yes ☐No

If Yes, Please Share With Us _____

_____

The above is accurate and true to the best of my knowledge.

_____ _____

(Signature) (Date)

_____ _____

(Signature of Parent or Guardian if Patient is a Minor) (Date)

Financial Responsibility

Who Is Responsible For Payment For Your Care? _____ Relationship _____

Insurance Company _____ Telephone # _____

ID # _____ Group # _____

Subscribers Name _____

Relationship To Subscriber: ☐Self ☐Spouse ☐Child Subscriber's Date Of Birth _____

Subscribers Address _____

Subscribers Employer _____

For Your Convenience We Will Keep Your Credit Card or Health Savings Account (HSA) Number On File. (Your Information Is Private And Protected Through HIPAA.)

Credit Card # _____ Expiration Date _____

Card Verification Value (CVV) # _____ Zip Code Associated With Card _____

Name (As It Appears On Card) _____ Signature _____

NOTICE: Your card may be charged for any deductible and/or outstanding balance on your account.