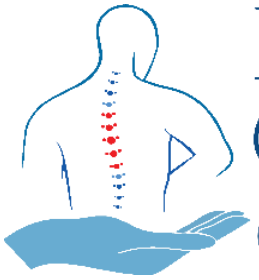


MY CHIRO CARE

ABOUT YOU

First Name: _____

Middle Name: _____

Last Name: _____

Street Address: _____

City: _____

State: _____

Zip: _____

Mobile Phone: _____

Work Phone: _____

Home Phone: _____

Email Address: _____

Date of Birth: _____/_____/_____ Is the patient under the age of 18:

Gender: Male Female

Height: ____’____”

Weight: _____

Marital Status: Single Married Separated Divorced

Widowed/ Other Spouse Name (if married): _____

How Did You Hear About Us: (check any that apply)

Word of Mouth Advertisement Social Media Direct Marketing Internet

What is your scheduled appointment (if scheduled)? _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____ Relation to you: _____

REASON FOR CONSULATION

How long have you had this complaint? (Circle best answer)

Less than 5 days (Acute) Between 5-30 days (Sub Acute) More than 30 days (Chronic)

What caused this condition? _____

What is the date this condition began? (Skip if it's a car accident) _____

What terms describe your discomfort best? _____

On the body diagram to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

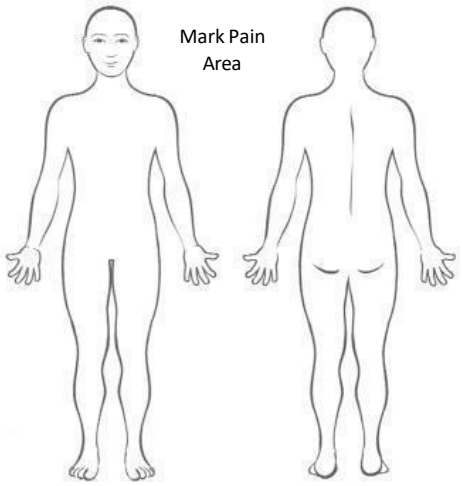
P- Pain

N- Numbness

W- Weakness

S- Shooting

A- Aching



On a scale of 1 to 10, with 10 being the most severe, what is your current level of discomfort?

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? Constant Frequent Occasional Intermittent

How has this complaint changed since the onset? Worsened Remain the same Improved

What activity is most significantly affected by this discomfort? (Explain)

_____

What treatment have you received for this condition up to now?

_____

What aggravates this condition?

_____

What improves this condition or give you relief?

_____

Have other health care provider(s) performed test related to this condition?

_____

Have you ever had any previous episode of this condition?

_____

Other than the information already provided, do you have any additional health concerns involving any of the following?

Muscle, Bones, or Joint

Nerves, Headaches, Dizziness, or Emotional

Head, Eyes, Ears, Nose or Throat

Heart, Blood Pressure, or Circulation

Shortness of Breath, Coughing, Asthma or Lung Condition

Stomach, Bowels or Digestive Conditions

Diabetes, Thyroid or Glandular Conditions

Skin or Bleeding Conditions

Allergies or Sensitivities

Have you had any surgical Procedures?

Are there any past illnesses or conditions we should be aware of?

Do you have any history of accidents or trauma?

Are you presently taking any medication?

Are there any past illnesses or conditions we should be aware of?

Do you have a past family illness history, such as diabetes, cancer, hypertension and progressive neurological disease that we should be aware of?

Current work habits: (select all that apply)

Permanently fully disable
Permanently partially disable
Cannot work due to current condition
Full time (20-40 hr/wk)
Part time (1-19 hr/wk)
Retired / Student / Homemaker / Unemployed

Personal social habits: (select all that apply)

Smoke or use tobacco products
Drink alcohol
Drink caffeine
Use recreation drugs
Other

Present exercise habits: (select all that apply)

No current exercise
Exercise daily
Exercise 3+ time per week
Cannot exercise due to current condition

Diet and nutrition habits: (select all that apply)

Vegan or vegetarian
Daily supplements
Other

MEN'S HEALTH

Do you have pain or a lump in your scrotum or testicles?

Do you have an impaired libido (sex drive)?

Do you have discharge from your penis?

Do you have prostate issue?

When was your last prostate exam?

Within the past year
Between 1 – 4 years
Greater than 5 years
Never had a prostate exam
Prefer not to answer or do not know

When was your most recent PSA (Prostate Specific Antigen) blood test?

Within the past year
Between 1 – 4 years
Greater than 5 years
Never had a PSA blood
Prefer not to answer or do not know

When was your PSA (Prostate Specific Antigen) level on your latest test?

Within the past year
Between 1 – 4 years
Greater than 5 years
Never had a PSA level done
Prefer not to answer or do not know

WOMEN'S HEALTH

Are you pregnant?

Are you nursing?

Are you taking birth Control?

Do you experience painful periods?

Do you have irregular cycles?

Do you have breast implants?

Do you perform a regular self-breast examination?

Do you take Hormone Replacement Therapy?

Do you take oral contraceptives?

When was your last PAP/ pelvic exam?

Within the past year
Between 1 – 4 years
Greater than 5 years
Never had a PAP or pelvic exam
Prefer not to answer or do not know

What was the date of your last menstrual period? (only answer if still menstruating)

Within the past month or currently
Between 1 – 3 months
Greater than 3 years
Postmenopausal
Have not yet begun menstruation
Prefer not to answer or do not know

When was your last mammogram?

Within the past year
Between 1 – 4 years
Greater than 5 years
Never had a mammogram exam
Prefer not to answer or do not know

CONSENT FOR TREATMENT

I certify that I am the patient or legal guardian listed above. I have read/ understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for the timely payment of such services. I understand and agree that health / accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date: _____/ _____/ _____

Legal Guardian Signature: _____ Date: _____/ _____/ _____
(Legal Guardian sign if patient is under 18 years old)