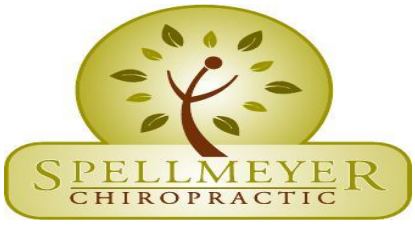


PERSONAL INFORAMTION

Name:_____ Date:_____
Birthday:_____ Age:_____
Address:_____
City:_____ Zip Code:_____
Home #_____Cell #:_____Work#:_____
E-mail Address:_____
Occupation:_____ Employer:_____
Marital Status: Single ☐Married ☐Divorce ☐Widow ☐
Spouse/Partner's Name:_____
Children
Name:_____ Age:_____ Gender ☐M☐F
Name:_____ Age:_____ Gender ☐M☐F
Name:_____ Age:_____ Gender ☐M☐F
Name:_____ Age:_____ Gender ☐M☐F

Who may we thank for referring you to out office? or how did you choose us?
☐Family/ Friend (name)_____☐Health Practitioner:_____
☐Website ☐Facebook ☐Walk-in ☐Other:_____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? ☐No ☐Yes, Date of last visit _____
Has a family member previously seen a chiropractor? ☐No ☐Yes, Spouse_____Child_____
Name of Chiropractor:_____
Reason for seeing them:_____
Describe your experience:_____
How frequently did you go for adjustment?_____
What made you decide not to return to see them?_____

IMPORTANT NOTE:

Today's visit will be focusing on assessing the health of your spine and nerves 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 depended 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 results 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 CONCERNS- FILL IN ALL AREAS Please check ☑ all that you have experienced in the last 12 months

☐ ADD/ ADHD	☐Congestion	☐G.I Issues	☐Prostate issues
☐ Allergies_____	☐Constipation/Gas	☐Hand/Wrist Pain	☐Reflux/Heartburn
☐ Anxiety	☐Cysts	☐Headaches/Migraines	☐Reproductive issues
☐ Asthma	☐Depression	☐Heart Disease	☐Sensory Processing
☐Autism	☐Diabetes	☐Hernias	☐Speech issues
☐Back pain	☐Diarrhea	☐High Blood Pressure	☐Stress
☐Upper ☐Mid ☐ Lower	☐Dizziness	☐Hip Pain	☐Swollen tonsils/Adenoids
☐Balance/Coordination	☐Ear Infections/Aches	☐Insomnia	☐Thyroid issues
☐Bladder	☐Eczema	☐Kidney issues	☐Tinnitus/Ringing Ears
☐Cancer	☐Epilepsy/Seizure	☐Knee/Ankle/Foot Pain	☐Ulcers
☐Chest Pain	☐Eye Pain	☐Metabolism issues	☐Vertigo
☐Chronic Cough	☐Focus/Memory Issues	☐Neck/Shoulder Pain	☐Vision/Hearing Loss
☐Chronic Fatigue	☐Food Sensitivities	☐Pneumonia/Bronchitis	☐Other:_____
☐Colds	☐Gallbladder issues	☐Poor Circulation	

Fill out ALL details below for the NEXT 3 most concerning conditions that you checked off:

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 medications for this condition? No☐ Yes☐ Please list:_____

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 medications for this condition? No☐ Yes☐ Please list:_____

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 medications for this condition? No☐ Yes☐ Please list:_____

Special Note: Have you taken any medication within the last 24 hours? No☐ Yes☐

Please list:_____

Which one of the above is your main concern about brought you to our office?_____

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

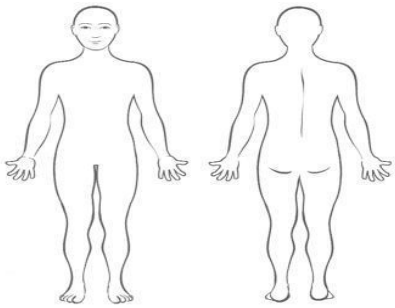
When did it start?_____ How? _____

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:_____

Where is the problem? Please circle or draw on the illustration 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 else have you tried and what were the results?_____

What parts of your life is this condition interfering with: ☐Work ☐Sleep ☐Exercise ☐Family ☐Social ☐Positive mental attitude ☐Hobbies ☐Others:_____

_____

Which part of your life is most important for you to get back to ASAP?_____

Beyond feeling better, what are 3 reasons you want to be healthier?

1. _____
2. _____
3. _____

Please list ALL OTHER medications you are currently taking and for what reason:_____

_____

_____

YOUR INJURY/SURGERY HISTORY

Have you had any surgery?

1. Type:_____ Date:_____ Hospitalized ☐No ☐Yes
2. Type:_____ Date:_____ Hospitalized ☐No ☐Yes

Accidents and/or injuries: Auto, Work related or other (especially those related to your present problems)

1. Type:_____ Date:_____ Hospitalized ☐No ☐Yes
2. Type:_____ Date:_____ Hospitalized ☐No ☐Yes

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:

1. Research show 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.
2. While extremely rare, there have been reports of ligament sprains and rib fractures.

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

☐ I understand that research and training is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes and understand that audio or video recordings may occur from time to time. (Your personal privacy is very important to us. We will not release any personal information).

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

Your name: _____ Signature:_____Date:_____

Witness:_____