



## REASON FOR VISIT

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Reason for today's visit:  Emergency  New injury  Old injury  Chronic pain  Wellness  
 Are you in pain:  Yes  No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense  
 Did your injury occur during:  Work  Sports/play  Auto Accident  Routine/Household activity  
 When did your condition/accident occur? \_\_\_ / \_\_\_ / \_\_\_ Where did your injury occur? \_\_\_\_\_  
 Please explain what happened: \_\_\_\_\_  
 Is your condition getting worse?  Yes  No  Constant  Comes and goes.  
 Is your condition interfering with your:  Work  Sleep or  Daily routine? If so, how: \_\_\_\_\_

Has this or something similar happened in the past?  
 Yes  No Explain: \_\_\_\_\_

**Using the adjacent body charts, please circle all affected areas.**

Have you been treated by a Medical Physician for this condition?  Yes  No If so, where? \_\_\_\_\_

Have you ever been treated by a Chiropractor?  Yes  No  
 Clinic or Dr's name: \_\_\_\_\_  
 Clinic phone#: \_\_\_\_\_



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## HEALTH HISTORY

**Are you taking any of the following medications?**  Nerve pills  Pain killers(including aspirin)  Muscle relaxers  
 Blood Thinners  Tranquilizers  Insulin  Other(s) \_\_\_\_\_

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

Family Health History: \_\_\_\_\_

Do you take Supplements or Vitamins?  Yes  No Do you exercise?  No  Yes \_\_\_\_\_ hours per week

Do you smoke?  No  Yes How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing:  Shoe lifts  Inner soles  Arch supports Are you dieting:  No  Yes Since: \_\_\_ / \_\_\_ / \_\_\_

**For women:** Are you taking Birth Control?  Yes  No  
 Are you Nursing?  Yes  No Are you Pregnant?  No  Yes If so, how many weeks? \_\_\_\_\_

- ◆ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_  
 Adult Patient  Parent or Guardian  Spouse

**UPDATE**  
(OFFICE USE)

Initials \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_  
 Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_  
 Comments \_\_\_\_\_

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 Comments \_\_\_\_\_

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