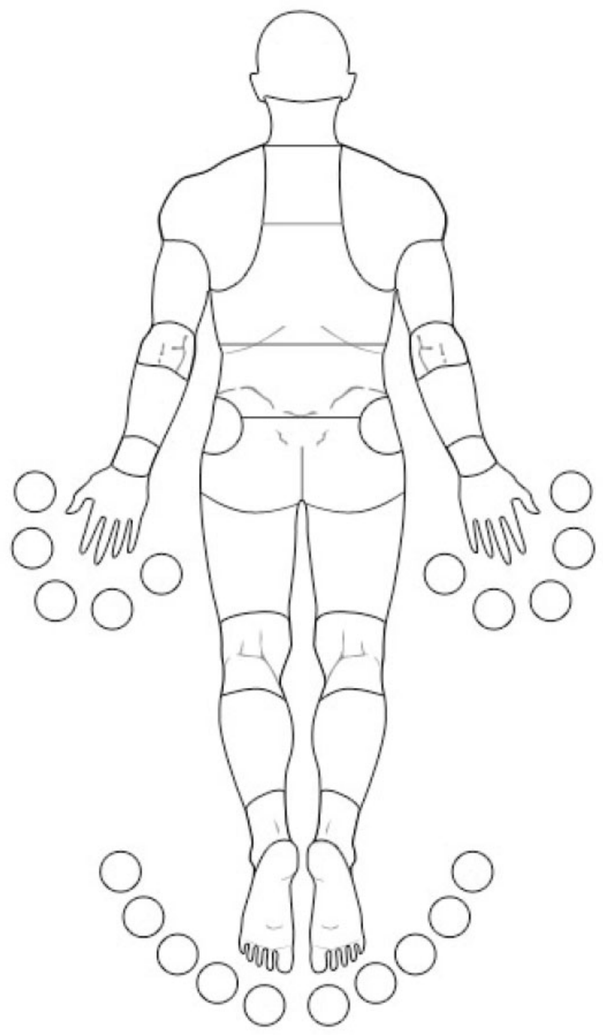
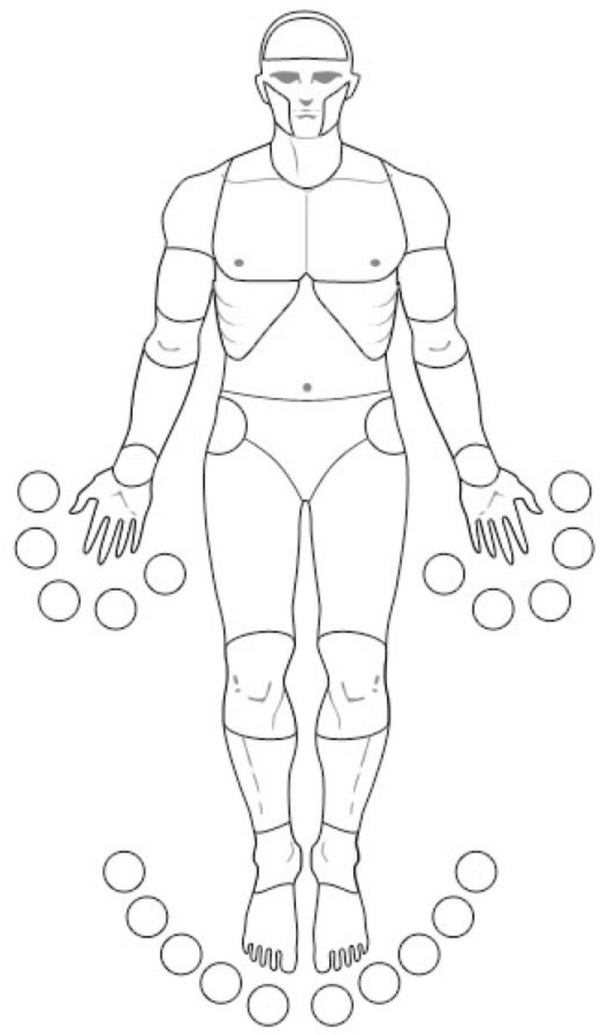
HEALTH

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin





HEADACHES	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Specifics	☐ Frontal ☐ Coronal ☐ Occipital ☐ Parietal ☐ Temporal ☐ Throughout
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Radiates to	☐ Neck ☐ Right Eye ☐ Left Eye ☐ Right Ear ☐ Left Ear ☐ Right Jaw ☐ Left Jaw
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bright lights ☐ Housework ☐ Loud noises ☐ Neck movements ☐ Watching T.V. ☐ Reading ☐ Working

Comments:_____

_____

NECK	
Location	☐ Right Front ☐ Left Front ☐ Right Back ☐ Left Back ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Stiffness ☐ Tightness ☐ ROM
Radiates to	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Both sides of head ☐ Right shoulder blade ☐ Left shoulder blade ☐ Right shoulder ☐ Left shoulder ☐ Right arm ☐ Left arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Light Activities ☐ Moderate Activities
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Neck Movement ☐ Sneezing ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Walking

Comments:_____

_____

MID BACK	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ Decreased ROM
Radiates to	☐ Neck ☐ Right Ribs ☐ Left Ribs ☐ Lower back
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ During Night ☐ Light Activities ☐ Moderate Activity
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Upper body movement ☐ Lifting ☐ Working ☐ Sneezing ☐ Housework ☐ Coughing ☐ Bending Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

_____

LOWER BACK	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Tightness ☐ Stiffness ☐ ROM
Radiates to	☐ Right Upper back ☐ Left Upper back ☐ Right Buttock ☐ Left Buttock ☐ Both Buttocks ☐ Right Hip ☐ Left Hip ☐ Right Thigh ☐ Left Thigh ☐ Right Calf ☐ Left Calf ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Range of motion ☐ Lifting ☐ Bending ☐ Lying down ☐ Working ☐ Housework ☐ Coughing. ☐ Sneezing Prolonged: ☐ Sitting ☐ Standing ☐ Walking

Comments: _____

_____

ARM OR LEG (circle one)	
Location	☐ Right Arm/Leg ☐ Left Arm/Leg ☐ Both Arms/Legs
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain/Severity	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling / ☐ Mild ☐ Moderate ☐ Severe
Associated with	☐ Numbness ☐ Bruises/Abrasions ☐ Tingling ☐ Increased sensitivity ☐ Weakness
Radiates to	☐ Right Shoulder/thigh ☐ Left Shoulder/thigh ☐ Right Elbow ☐ Left Elbow ☐ Right Forearm/Calf ☐ Left Forearm/Calf ☐ Right Hand/Foot ☐ Left Hand/Foot ☐ Right Fingers/Toes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Left Fingers/Toes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst	☐ Afternoon ☐ Evening ☐ Light Activities ☐ Moderate Activities ☐ Morning
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Movement ☐ Housework ☐ Lifting ☐ Driving ☐ Working

Comments: _____

_____

Other Area of Complaint		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

OTHER COMPLAINTS:

☐ Balance loss ☐ Fatigue ☐ Irritability ☐ Memory loss ☐ Nervousness ☐ Tension ☐ Shortness of breath

_____

Patient's Signature

Medical History Information

Last Name:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
First Name:	Middle:			Single / Mar / Div / Sep / Widow
Email:		Birth date:	Age:	Sex:
Address:	City:		State:	
ZIP Code:	Social Security No.:	Home Phone:		
Occupation:	Employer:	Phone:	Cell phone:	

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have You Had Chiropractic Care In The Past? ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Currently Pregnant Due Date:	☐ Taking Birth Control
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Date of Last Cycle
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Thyroid trouble	☐ Ulcer
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Epilepsy	☐ Polio
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐
Other:					

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus
Other:					

Type of Cancer:	☐ Breast ☐ Lung ☐ Other:
Social History:	

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous
Misc.:			

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

IN CASE OF EMERGENCY

Please Contact:

Name	Phone Number	Relationship to patient

INFORMED CONSENT TO TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me or on the patient named below for whom I am legally responsible for by the Doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below, or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel regarding the nature and purpose of chiropractic adjustments and procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do expect the doctor to exercise judgment during the course of the procedure which the doctor feels, at the time, based upon the facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to discuss or ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any conditions in the future for which I seek treatment.

SIGNATURE _____ DATE _____

*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.
*I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE _____ DATE _____

By my initials _____, I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance unpaid by the insurance company.

*Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements are made with the office manager. **How will you be paying for today's visit?**
_____CASH _____CHECK _____CREDIT CARD _____GIFT CERT. _____ACCIDENT