α CHIROPRACTIC FIRST

Please print clearly and fill in completely

Print Name _____ Date _____

Street/Mailing Address _____ City _____

State _____ Zip Code _____ Email Address _____ Preferred Language _____

Home Phone _____ Work Phone _____

Cell Service Provider & Number _____

Date of Birth _____ Social Security # _____

Please check: Sex: Male ❑ Female ❑ Married ❑ Single ❑

Where did you hear about our office or who referred you? _____

Personal & Family History:

Your occupation: _____ Employer: _____

Address: _____ City _____ State _____ Zip Code _____

Spouse _____ Spouse's health status _____

Children's names, ages & health status: _____

FEMALES ONLY: Please check one ☑ Is there a possibility of you being pregnant? Yes ❑ No ❑

Chiropractic History:

Have you ever been to a Chiropractor before? Yes ❑ No ❑ If yes, Doctor's name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? Yes ❑ No ❑

Rate your health & wellness:

Place an "X" in the box that denotes where you believe your current level of wellness is at.
Place an "O" indicating where you would like your wellness.

Wellness Commitment

At this chiropractic office, we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment,* but we do ask for your *cooperative commitment.* Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10%---------20%---------30%---------40%---------50%----------60%----------70%----------80%----------90%----------100%

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes ❑ No ❑ If yes, the conditions being treated for: _____

_____

List any current medications , dosage, and frequency information and how long you have taken each medication:

❑ Pain meds (over the counter/prescription) _____

❑ Birth Control _____

❑ Heart Meds _____

❑ Cholesterol Meds _____

❑ Antidepressant/Anti-anxiety Meds _____

❑ Recreational Drugs _____

❑ Anti-Inflammatory Meds _____

❑ Muscle Relaxers _____

❑ Aspirin _____

❑ Blood Pressure _____

❑ Diabetes Meds _____

❑ Other _____

❑ Medication Allergies _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Have you ever had any broken bones/fractures? _____

Please check all of the following health concerns you have experienced, even if you do not think that your answers relate to your to your present health concern.

Allergies	Yes ❑ No ❑	Heart Condition	Yes ❑ No ❑
Anxiety	Yes ❑ No ❑	Immune System Disorder	Yes ❑ No ❑
Arthritis	Yes ❑ No ❑	Infertility	Yes ❑ No ❑
Asthma	Yes ❑ No ❑	Kidney Disease	Yes ❑ No ❑
Back Pain	Yes ❑ No ❑	Menstrual Cramps/Problems	Yes ❑ No ❑
Bladder Problems	Yes ❑ No ❑	Mood Swings	Yes ❑ No ❑
Cancer	Yes ❑ No ❑	Neck Pain	Yes ❑ No ❑
Circulatory/Vascular Disorder	Yes ❑ No ❑	Numbness/Tingling	Yes ❑ No ❑
Depression	Yes ❑ No ❑	Osteoporosis	Yes ❑ No ❑
Diarrhea/Constipation	Yes ❑ No ❑	Sinus Trouble	Yes ❑ No ❑
Digestive Problems	Yes ❑ No ❑	Skin Conditions	Yes ❑ No ❑
Dizziness	Yes ❑ No ❑	Sleep Challenges	Yes ❑ No ❑
Headaches	Yes ❑ No ❑	Urinary Difficulty	Yes ❑ No ❑
Heartburn/Reflux	Yes ❑ No ❑	Vertigo	Yes ❑ No ❑
		Other _____	

Stress History:

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to **determine which factors have contributed** to your present health concerns.

1. Childhood

Repeated/Prolonged Antibiotic Use	Yes ❑ No ❑	Inhaler Use	Yes ❑ No ❑
Car Accident	Yes ❑ No ❑	Prescription Medications	Yes ❑ No ❑
Childhood Illness	Yes ❑ No ❑	Surgery	Yes ❑ No ❑
Fall/Jump from a height < 3 feet	Yes ❑ No ❑	Vaccination	Yes ❑ No ❑
Fall/Jump from a height > 3 feet	Yes ❑ No ❑	Youth Sports	Yes ❑ No ❑
Head Trauma	Yes ❑ No ❑	Other Traumas (physical or emotional):	
		_____	

2. Adulthood

Alcohol Consumption	Yes ❑ No ❑	Inhaler Use	Yes ❑ No ❑
Repeated/Prolonged Antibiotics	Yes ❑ No ❑	Prescription Medications	Yes ❑ No ❑
Car Accident	Yes ❑ No ❑	Smoking Status: Everyday, Occasional, Former, Never	
Coffee Drinker	Yes ❑ No ❑	Surgery	Yes ❑ No ❑
Drug Use/Abuse	Yes ❑ No ❑	Contact Sports	Yes ❑ No ❑
Fall/Jump from a height	Yes ❑ No ❑	Extreme Sports	Yes ❑ No ❑
Head Trauma	Yes ❑ No ❑	Workplace Stress	Yes ❑ No ❑
Home Environment Stress	Yes ❑ No ❑	Other Traumas (Physical or emotional):	
		_____	

Lifestyle Information:

Do you exercise? Yes ❑ No ❑ If yes, how much & how often? _____

Do you use tobacco? Yes ❑ No ❑ If yes, what type? _____

Lifestyle Information (cont.):

Do you consume alcohol? Yes ❑ No ❑ If yes, how much & how often? _____

Do you drink soft drinks (diet or regular)? Yes ❑ No ❑ If yes, how much? _____

Do you drink water? Yes ❑ No ❑ If yes, how much? _____

Do you drink coffee? Yes ❑ No ❑ If yes, how much? _____

How would you rate your nutritional habits? Great ❑ Good ❑ Fair ❑ Poor ❑

Do you take any vitamins/supplements? Yes ❑ No ❑ If yes, what kind? _____

How many hours of sleep do you usually get? _____ Is the quality of sleep Good ❑ Fair ❑ Poor ❑

Stress level (personal): Low ❑ Medium ❑ High ❑

Stress level (at work): Low ❑ Medium ❑ High ❑

What do you do to relieve or handle your stress? _____

Which best describes your reason for consulting our office? (Please choose only one)

- ❑ I have a specific concern and require help only with this concern.
- ❑ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
- ❑ I want to be healthier five years from now that I am today

ASSIGNMENT & RELEASE:

We accept payment by cash, check & credit card

Who is responsible for this account? _____

Relationship to Patient _____

I, the undersigned, hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing. I certify that all information is filled out accurately to the best of m knowledge.

❑ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

_____

Responsible Party Signature Date Relationship to Patient

_____

Patient Signature Date