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## REASON FOR VISIT

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: \_\_\_\_\_

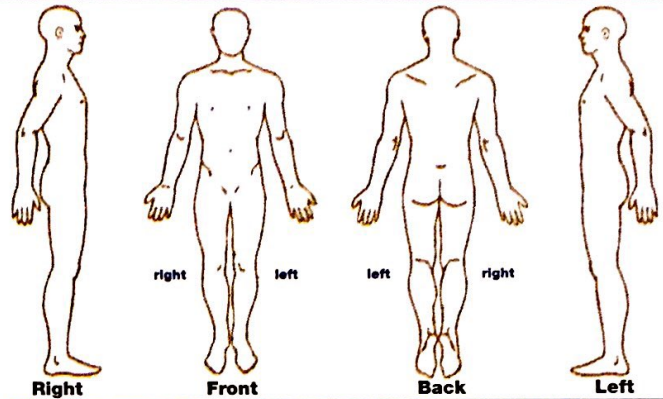
**Using the adjacent body charts, please circle all affected areas.**

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#: \_\_\_\_\_



Right

Front

Back

Left

6

## 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 \_\_\_\_\_

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

Comments \_\_\_\_\_