

Welcome to our office! Please provide us with the following information for our records.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Prefer to be called: \_\_\_\_\_  
LAST FIRST MIDDLE

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) Work Phone: ( \_\_\_\_\_ )

Cell Phone: ( \_\_\_\_\_ ) Fax Number: ( \_\_\_\_\_ )

Which is the best number to contact you or to leave a message?  Home  Work  Cell

Birth Date: \_\_\_\_\_

Sex:  M  F Marital Status:  S  M  P  D  W

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address/City/State/Zip: \_\_\_\_\_

In Case of Emergency-Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) Cell/Work Phone: ( \_\_\_\_\_ )

Referred By: \_\_\_\_\_

Physician's Name and Address: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

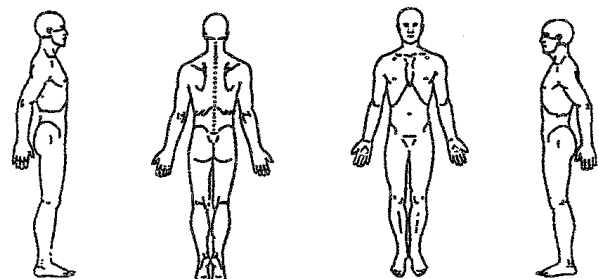
PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below please describe the present complaint(s) that brought you to this clinic for chiropractic care. The information you provide concerning the past and present symptoms assist your doctor in obtaining an early understanding of your state of health.

- 1. Present Complaint: \_\_\_\_\_
- 2. Please describe the character of your current pain (you may check one or more answers):  Sharp/Stabbing  Sharp/Dull  Aches  Dull  
 Soreness  Weakness  Throbbing/Gnawing  Numbness  Shooting  Gripping/Constricting  Burning  Tingling
- 3. How often are the complaints present?  Constant (76-100%)  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)
- 4. How bad is your pain or ache? Please check a number:  0  1  2  3  4  5  6  7  8  9  10  
NO PAIN UNBEARABLE
- 5. Since your problem began the pain is:  Increasing  Decreasing  Not Changing
- 6. Did your problem begin:  Immediately after a specific accident  Multiple incidents  Gradually developed over time
- 7. When did your problem begin? (list specific date if possible): \_\_\_\_\_
- 8. Describe how your problem began: \_\_\_\_\_
- 9. What treatment have you received for this present condition?  None  Therapy from PT  A back support  Surgery  Spinal injections  
Other: \_\_\_\_\_
- 10. Were you previously treated for a different occurrence of this same condition?  Yes  No If yes, by:  Chiropractor  MD  Therapy  
Other: \_\_\_\_\_ Specify dates and type of treatment: \_\_\_\_\_
- 11. What makes your problem better?  Nothing  Laying down  Walking  Standing  Movement/Exercise  Inactivity  
Other: \_\_\_\_\_
- 12. What makes your problem worse?  Nothing  Laying down  Walking  Standing  Movement/Exercise  Inactivity  
Other: \_\_\_\_\_
- 13. How would you grade your stress level?  No Stress  Minimal Stress  Moderate Stress  Greatly Stressed
- 14. Physical activity at work:  Sedentary (More than 50% of Workday)  Light Manual Labor  Manual Labor  Heavy Manual Labor
- 15. General physical activity:  No Regular Exercise Program  Light Exercise program  Strenuous Exercise Program
- 16. Are your complaints affecting your ability to work or otherwise be active?  No effect  Some physical restrictions (able to do light duty tasks)  
 Need limited assistance with common everyday tasks  Need assistance often  Have a significant inability to function without assistance  
 Am totally disabled (impaired)/Cannot care for self

Mark an X on the picture where you continue to have symptoms—including pain, numbness, tingling etc.

Do you want further information/or have additional questions regarding:  
\_\_\_\_\_

Any suggestions how we can improve our service to you and to others:  
\_\_\_\_\_



Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV            | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes         | <input type="checkbox"/> Yes <input type="checkbox"/> No Measles              | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcoholism          | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema        | <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine Headaches   | <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy Shots       | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy         | <input type="checkbox"/> Yes <input type="checkbox"/> No Miscarriage          | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures        | <input type="checkbox"/> Yes <input type="checkbox"/> No Mononucleosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No Suicide Attempt    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anorexia            | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma         | <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis   | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Appendicitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No Goiter           | <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps                | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No Gonorrhea        | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma              | <input type="checkbox"/> Yes <input type="checkbox"/> No Gout             | <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker            | <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors or Growths  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder   | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No Typhoid Fever      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Lump         | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No Pinched Nerve        | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia           | <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia            | <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal Infections |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bulimia             | <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated Disk   | <input type="checkbox"/> Yes <input type="checkbox"/> No Polio                | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes           | <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Problem     | <input type="checkbox"/> Yes <input type="checkbox"/> No Whooping Cough     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cataracts           | <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis           | <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care     | _____   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox         | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis | _____   |

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day \_\_\_\_\_

Drinks/Week \_\_\_\_\_

Cups/Day \_\_\_\_\_

Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Describe Injuries/Surgeries you have had:

Date:

Falls \_\_\_\_\_

\_\_\_\_\_

Head Injuries \_\_\_\_\_

\_\_\_\_\_

Broken Bones \_\_\_\_\_

\_\_\_\_\_

Dislocations \_\_\_\_\_

\_\_\_\_\_

Surgeries \_\_\_\_\_

\_\_\_\_\_

Welcome to 6330 Telegraph Ave.

The purpose of the following agreement is to help serve you.

#### PAYMENT OF BILLS

We request that charges be paid in full at the time of service. After your initial office visit, you may pay once at the end of the week if you have multiple appointments in a single week. We will expect you to honor the financial agreements you make with our office. If you find that your circumstances change, advise the doctor/staff immediately so new arrangements can be made. Private insurance companies will not be billed.

#### MISSING OR CHANGING APPOINTMENTS

If you miss an appointment or cancel with less than 24-hour notice, there will be a missed visit charge.

#### PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, progress evaluations and check-ups may take place. Depending on the complexity/length of time for these visits, additional fees may apply.

#### FOR PATIENTS REGARDING PERSONAL INJURY (EXAMPLE: MOTOR VEHICLE INSURANCE)

Please understand that your insurance policy is an agreement between you and your insurance company. You are financially responsible for all services rendered to you in our office. We are willing to bill your auto insurance carrier directly upon proof of available medical-payment coverage. If you miss an appointment or cancel with less than 24-hour notice, you will be charged a full appointment fee. We will not bill insurance companies for missed appointments. You are personally responsible for missed/cancelled visit charges.

I have read the above and I understand and accept these policies.

Name: \_\_\_\_\_

Date: \_\_\_\_\_