WELCOME TO WE CARE CHIROPRACTIC!

TODAY'S DATE_____

PATIENT INFORMATION:

Name_____ Date of Birth_____
Last First Middle (Maiden)

Address_____ City_____ State_____ Zip_____

Home Ph(_____)_____ Work Ph(_____)_____

Cell Ph(_____)_____ Cell phone provider_____

Female□ Male□ Age_____ Single□ Married□ Divorced□ Widowed□ Email:_____

Employer_____ Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Name of Spouse_____ Phone(_____)_____

Emergency Contact_____ Relationship_____ Phone(_____)_____

Whom May We Thank for Referring You?_____

RESPONSIBLE PARTY INFORMATION:

Name of Person Financially Responsible for this Account_____
Last First Middle (Maiden)

Relationship to Patient_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Phone(_____)_____ Employer_____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I, _____,BEING THE PARENT OR LEGAL GUARDIAN OF
First Middle Last

_____HEREBY GRANT PERMISSION FOR THIS CHILD
First Middle Last

TO RECEIVE CHIROPRACTIC CARE INCLUDING ANY NECESSARY PHYSICAL EXAM, X-RAY, AND SPINAL ADJUSTMENT.

_____ _____ _____
Signature of Parent/Legal Guardian Relationship to Patient Date

I CERTIFY THAT THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

I AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES WHETHER OR NOT COVERED BY MY INSURANCE. PAYMENT IN FULL IS EXPECTED WHEN SERVICES ARE RENDERED. NON-PAYMENT OF MY ACCOUNT MAY RESULT IN ADDITIONAL COLLECTION AND/OR ATTORNEY FEES AND COURT COSTS.

I HEREBY GIVE MY PERMISSION TO THIS OFFICE TO RELEASE ANY INFORMATION REQUIRED BY MY INSURANCE COMPANY ACQUIRED IN THE COURSE OF MY CARE. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO WE CARE CHIROPRACTIC.

_____ _____ _____
Signature Relationship to Patient Date

TERMS OF ACCEPTANCE

When a person seeks Chiropractic health care and we accept that person for such care, it is essential for both to be working towards the same objective.

HEALTH: A state of optimal physical, mental, social, and spiritual well being, not merely the absence of disease or infirmity.

SPINAL ADJUSTMENT: A spinal adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the spinal adjustments.

I have read and fully understand the above statements.

All questions regarding the chiropractor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

PREGNANCY RELEASE

THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT AND THE ABOVE CHIROPRACTOR AND HIS ASSOCIATES HAVE MY PERMISSION TO PERFORM AN X-RAY EVALUATION. I HAVE BEEN ADVISED THAT X-RAY CAN BE HAZARDOUS TO AN UNBORN CHILD.

DATE OF LAST MENSTRUAL PERIOD:_____

_____ _____

Signature Date

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME _____ BIRTH DATE _____ Date _____
(last) (first) (middle)

HEIGHT _____ WEIGHT _____ SEX _____ Case No. _____

CHILDREN (list ages & sex) _____

Describe major complaints & symptoms (indicate areas of pain on reverse side of this form)

_____

_____

Date you first noticed symptoms _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL FREQUENT

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE & JOINT
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, Numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

GASTRO-INTESTNAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digestion
- ☐ ☐ Distention of abdomen
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noises
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Slow heart beat
- ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal discharge

Pregnant ☐ Yes ☐ No
Date of last period _____
Previous miscarriages ☐ Yes ☐ No

DATE OF LAST: (Approx.)
- _____ Physical examination
- _____ Blood test
- _____ Chest x-ray
- _____ Spinal x-ray
- _____ Dental x-ray
- _____ Urine test

	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries - _____

_____

_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Pacemaker	☐ Stroke	☐

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

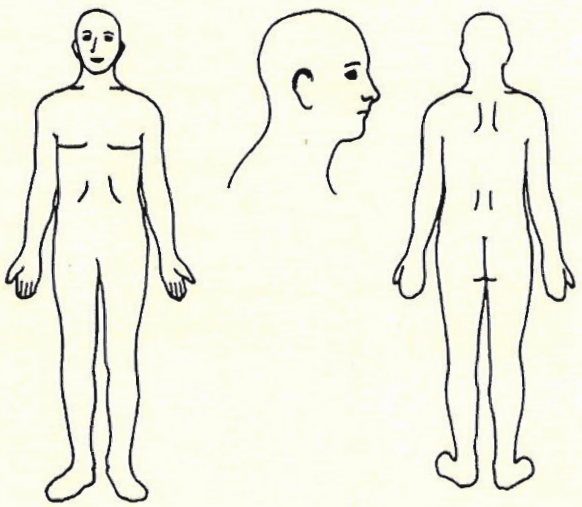
Sign Your Name _____ Date _____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY

CASE HISTORY

Please mark your areas of pain on the figures below.



PATIENTS COMMENTS:

DOCTORS COMMENTS

Quality of Life Questionnaire

Name:_____ Date:_____

Rate the following with respect to frequency	Never	Occasional			Regular			Frequent			Constant
Presence of physical pain (neck/back ache, arm/leg pain, radiating pain, sciatica, etc.)	0	1	2	3	4	5	6	7	8	9	10
Feeling of tension or stiffness or lack of flexibility in your spine	0	1	2	3	4	5	6	7	8	9	10
Incidence of fatigue or low energy	0	1	2	3	4	5	6	7	8	9	10
Incidence of nausea , diarrhea, and/or constipation	0	1	2	3	4	5	6	7	8	9	10
Incidence of headaches (of any kind)	0	1	2	3	4	5	6	7	8	9	10
Incidence of dizziness or ringing in the ears	0	1	2	3	4	5	6	7	8	9	10
Presence of stress and anxiety over current health conditions	0	1	2	3	4	5	6	7	8	9	10

Please circle the activities that are affected by your current health condition and rate the severity to which they are affected by using the scale provided.

	Mild				Moderate					Severe	
Sitting	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Driving	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Yard Work	0	1	2	3	4	5	6	7	8	9	10
Bathing/ Grooming	0	1	2	3	4	5	6	7	8	9	10
Dressing	0	1	2	3	4	5	6	7	8	9	10

	Mild				Moderate					Severe	
Sleeping	0	1	2	3	4	5	6	7	8	9	10
Traveling	0	1	2	3	4	5	6	7	8	9	10
Occupational duties	0	1	2	3	4	5	6	7	8	9	10
Exercising	0	1	2	3	4	5	6	7	8	9	10
Cooking	0	1	2	3	4	5	6	7	8	9	10
Shopping	0	1	2	3	4	5	6	7	8	9	10
Housework	0	1	2	3	4	5	6	7	8	9	10
Caring for a dependent	0	1	2	3	4	5	6	7	8	9	10