WELCOME
TO THE CHIROPRACTIC HEALTH CLINIC!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION

Name_____Social Security#_____Date_____

Address_____City_____State_____Zip_____

Phone_____Cell Phone_____

Gender: Male or Female Age_____Birth Date_____Height_____Weight_____

Occupation_____Employer_____Years_____

Employers Address_____Work#_____

Notify in case of Emergency_____Phone_____

INSURED'S NAME_____**DATE OF BIRTH**_____

Who may we Thank for Referring You?_____

REASON FOR VISIT

Please inform us if this is an auto accident or work injury. Yes or No **Auto**_____**Work**_____

Have you ever seen a Chiropractor? Yes or No If yes, when and why?_____

Your reason for this Visit?_____

When did symptoms begin?_____Have you had similar conditions in the past?_____

What aggravates your condition?_____

Is this condition getting progressively worse? Yes or No Constant_____Comes and goes_____

Other doctors who treated you for this condition?_____

List any medications you are taking_____

List Surgical Operations and Years_____

Have you ever been in an Auto Accident? Yes or No If Yes, When?_____

Have you had any Personal Injury or Work Accident? Yes or No If Yes, When_____

I clearly understand and agree that all services rendered me are charged directly to me or my insurance company and that I am personally responsible for any balance due.

AUTHORIZING SIGNATURE_____**DATE**_____

INFORMATION REQUIRED FOR YOUR CASE HISTORY FILE

Name: _____ Date: _____

Describe your current problem and how it began: _____

_____

Current complaint -------- On a scale of 0 to 10 -------- Circle how you feel today?

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Severe Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

_____

ANY FAMILY HISTORY OF: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

Please check any boxes that pertain to you:

Past	Present	Condition
☐	☐	History of Recent Infection
☐	☐	Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Cancer/Tumor_____
☐	☐	Dizziness/Fainting

Past	Present	Condition
☐	☐	Prostate Problems
☐	☐	Urinary, Frequent Urination
☐	☐	*Pregnancy, # of births _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Distrubances
☐	☐	Alcohol Use
☐	☐	Tobacco Use
☐	☐	Surgeries/Medications: _____
		_____
☐	☐	Osteoporosis

HEAD

☐ Headache ☐ Migraine
☐ entire head ☐ back of head
☐ forehead ☐ temples
☐ Loss of memory
☐ Lightheadedness
☐ Fainting ☐ Lights bother eyes
☐ Loss of smell ☐ Loss of taste
☐ Loss of balance
☐ Dizziness ☐ Loss of hearing
☐ Pain in ears ☐ Ringing in ears

NECK

☐ Pain in neck ☐ Stiff neck
☐ Neck feels out of place
☐ Muscle spasms in neck
☐ Grinding/grating sounds
☐ Popping sounds

SHOULDERS

☐ Pain in shoulder joint (R-L)
☐ Pain across shoulders
☐ Bursitis (R-L) ☐ Arthritis (R-L)
☐ Can't raise arm (L-R)
☐ Tension in shoulders

ARMS & HANDS

☐ Pain in upper arm
☐ Pain in forearm
☐ Pain in hands ☐ Pain in fingers
☐ Sensation of pins & needles
☐ Fingers go to sleep
☐ Hands get cold
☐ Swollen joint in fingers
☐ Sore joints in fingers
☐ Loss of grip strength

MID BACK

☐ Mid back pain
☐ Pain between shoulder blades
☐ Sharp, stabbing pain mid back
☐ Muscle spasms

CHEST

☐ Chest pain
☐ Shortness of breath
☐Pain around ribs

ABDOMEN

☐ Nervous stomach
☐ Nausea ☐ Gas
☐ Constipation ☐ Diarrhea

LOW BACK

☐ Low back pain
☐ Pinched nerve in low back
☐ Slipped disc
☐ Muscle spasms

HIPS, LEGS & FEET

☐ Pain in buttocks (R-L)
☐ Pain in hip joint (R-L)
☐ Pain down legs (R-L)
☐ Pain down both legs
☐ Leg cramps ☐ Pins & needles
☐ Numbness of legs (R-L)
☐ Numbness of feet (R-L)
☐ Numbness of toes
☐ Feet feel cold
☐ Cramps in foot (R-L)
☐ Swollen ankles (R-L)
☐ Swollen feet (R-L)

*WOMEN ONLY

☐ Are you Pregnant? ☐Yes ☐ No
If yes: How many Months: _____
☐ Menstrual pain ☐ Cramping
☐ Irregularity

CHIROPRACTIC HEALTH CLINIC

Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Chiropractic Health Clinic or on your relationship with our staff.

Patient Authorization for appointment reminders and scheduling related matters

It is our desire for our staff to use you name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues. If you are not at home to receive an appointment reminder, a message may be left on your answering machine.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from Chiropractic Health Clinic or on your relationship with our staff.

Patient Authorization for allowing our office to post pictures of your child or children in our office, if they would like to have their picture on our board

Your signature below indicates your authorization of these activities.

Name (printed)	Signature	Date

If you are a minor, or if you are being represented by another party:

Personal Representative (Printed)	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the changes in our system to be completed.