Welcome to our office, where it is our mission to build a community where people are as healthy as possible with out the use of drugs or surgery! It is well known that families who maintain strong, healthy, well aligned spines have overall better health.

Confidential Patient Health Record

Date:_____

Name: _____ **Home Phone: (**_____**)**_____

Address: _____ **City:**_____ **ST:**_____ **ZIP:**_____

Birth Date: _____ **Age** _____ **Sex:** ☐ **Male** ☐ **Female**

Social Security #: _____

Email: _____ **Cell Ph: (**_____**)**_____

Employer:_____ **Type of work:**_____ **Work Ph:** _____

Circle One: Married Single Widowed Divorced Separated

Name of Spouse: _____ **Spouse Employer:**_____

Name & Ages of Kids: _____

How did you hear about our office? _____

Name & Number of Emergency Contact: _____ **Relationship:**_____

Personal Health Insurance (Name & Number)_____ **& #**_____

Insured Persons Name: _____ **Date of Birth:** _____

Current Health Condition

Have you ever been to a Chiropractor before? ☐ **Yes, When?** _____ ☐ **No**

Have you ever had an x-ray taken of your spine? ☐ **Yes, When?** _____ ☐ **No**

Unwanted Health Concern/ Chief Complaint: _____**How Long?** _____

Is this visit related to an accident or injury? ☐ **Yes, Date of accident:**_____/_____/_____ ☐ **No**

Spinal health is especially important during pregnancy- any chance you are pregnant? ☐ **Yes** ☐**No**

✎ **Please check off any of the following symptoms that you have experienced in the past 12 months:**

- ☐ Tension across top of shoulders
- ☐ Pain between shoulder blades
- ☐ Neck Pain
- ☐ Headaches/Migraines
- ☐ TMJ
- ☐ Carpal Tunnel Syndrome
- ☐ Thyroid/Throat Problems
- ☐ Numbing/Tingling in arms/hands
- ☐ Allergies/Asthma
- ☐ Dizziness
- ☐ Arthritis/Joint Pain
- ☐ Fibromyalgia
- ☐ Poor Vision/ Eye Problems
- ☐ Difficulty Sleeping
- ☐ Tinnitus/ Hearing Problems
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Frequent Colds

- ☐ High/Low Blood Pressure
- ☐ Breathing Problems
- ☐ Mid-back/Shoulder Pain
- ☐ Digestive Problems
- ☐ Diabetes/Blood sugar Problems
- ☐ Poor Digestion
- ☐ Anxiety/Overwhelmed Feeling
- ☐ Eczema/Psoriasis/Dry Skin
- ☐ Acid Reflux/Stomach Issues
- ☐ Fatigue/Low Energy
- ☐ Stress-related problems
- ☐ Autoimmune/Rheumatism

- ☐ Low Back Pain
- ☐ Gas/Bloating
- ☐ Irritable Bowel Syndrome
- ☐ Constipation/ Diarrhea
- ☐ Infertility/Inability to get Pregnant
- ☐ Menstrual problems/PMS syndrome
- ☐ Numbing/Tingling in legs/feet
- ☐ Prostate Problems
- ☐ Sciatica/Leg Pain
- ☐ Knee/Ankle/Hip problems
- ☐ Sexual Dysfunction
- ☐ Muscle Pain in hips/buttocks

How would you rate your health in the following categories (1= bad, 10= perfect)?

Energy Levels (without caffeine or other stimulants): 1 2 3 4 5 6 7 8 9 10

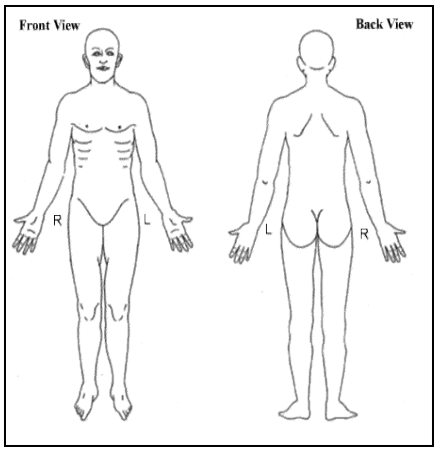
Mental Clarity (without caffeine or other stimulants): 1 2 3 4 5 6 7 8 9 10

Sleep Quality (how refreshed do you feel in the morning): 1 2 3 4 5 6 7 8 9 10

Flexibility (ease of movement, bending, turning, etc): 1 2 3 4 5 6 7 8 9 10

Digestive Health (normal is 1-2 bowel movement/day): 1 2 3 4 5 6 7 8 9 10

Overall Health: 1 2 3 4 5 6 7 8 9 10



Please indicate on the diagram the area of your discomfort

Most patients that come to our office have on two objectives in mind concerning their heath care. Some patients come for symptomatic **relief of pain or discomfort (Relief Care).** Others are interested in having the **cause of the problem** as well as the **symptoms corrected and relieved (Corrective Care).** Your Doctor will weigh your needs when recommending you treatment Program.

Please check the type of care desire so that we may be guided by your wishes whenever possible.

- ☐ **Relief Care:** Necessary to get rid of symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.
- ☐ **Corrective Care:** its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective Care varies in the length of time, but is more lasting.
- ☐ **Check here if you want the Dr. to select the type of care appropriate for your condition**

I understand and agree that health & accident insurance policies are an arrangement between and insurance carrier & myself. Furthermore, I understand that the Doctors office will prepare any necessary reports & forms to assist me in making collection from the insurance company& that any amount authorized to be paid directly to the Doctors office will be credited to my receipt. However, I clearly understand & agree that all fees for professional services rendered to me will be due & payable.

Signature of Patient or guardian: _____ **Date:**_____

Please list any medications that you are currently on:

Name of Medication	What for?	Any Side Effects?