

Fill out the next three sections as they apply to you

Headaches

Do you have a family history of headaches? Yes No Do you get headaches? Yes No
 Do you experience the following along with your headaches: Pain or cracking in your jaw? Yes No
 Abnormal blood pressure? Yes No High Or Low Nausea, Vomiting or Visual disturbances? Yes No
 When was your last eye exam by a doctor? 1-6 months 6-12 months 1-2 years over 2 years Results:

Lower Back Pain

Do you ever experience ripping or tearing sensations in your back? Yes No
 Does pain radiate to the abdomen? Yes No
 Do you ever have impairment of bowel or urinary function? Yes No Explain:

Neck Pain

If you have neck injury, does it effect: (check all that apply) hearing vision balance cause ringing in your ears
 Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No
 Do you feel ripping or tearing? Yes No Where? _____
 Do you have difficulty lifting or turning your head? Yes No If so in what direction? Right Left Up Down

Height _____ Weight Now _____ One Year Ago _____ Change in last two years _____
 Weight Maximum _____ Age _____ Adult Minimum _____ Age _____
 Are you dieting? Yes No How? _____
 Are you a vegetarian? Yes No If No, how often do you eat red meat? _____
 How often do you have a bowel movement? _____
 Do you drink caffeinated beverages? Y N What kind? _____ Cups/day _____
 Do you smoke? Y N How many per day? _____ Since when? _____
 Do you use other tobacco products? Y N What? _____
 Average number of alcoholic drinks/week? ____ Have you had any surgeries or hospitalizations? Yes No Please List:

| | | | |
|---|-------------|---|-------------|
| Type of Hospitalization / Surgery _____ | Date: _____ | Type of Hospitalization / Surgery _____ | Date: _____ |
| | | | |

Women only: Menstrual History

Date of onset of last period ____/____/____ Age of onset _____ Are your periods regular? Y N
 If not explain _____
 Do you experience cramping? _____ Do you have any premenstrual symptoms? _____
 If so, what? _____
 Are you currently pregnant? Y N Are you currently using birth control? Y N What? _____

Additional Complaints

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Numbness in fingers, arms, legs | <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Extreme fatigue |
| <input type="checkbox"/> Head seems to heavy | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nausea, Vomiting | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain radiating into |
| <input type="checkbox"/> Equilibrium Problems | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Right arm |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Difficulty in excessive lifting | <input type="checkbox"/> Left arm |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Ears buzzing/ringing | <input type="checkbox"/> Light | <input type="checkbox"/> Both arms |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Moderate | <input type="checkbox"/> Right leg |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Repetitive | <input type="checkbox"/> Left leg |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Extreme nervousness | <input type="checkbox"/> Difficulty in excessive | <input type="checkbox"/> Both legs |
| <input type="checkbox"/> Neck motion restricted | <input type="checkbox"/> Tension | <input type="checkbox"/> Standing | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Upper back pain/stiffness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Walking | <input type="checkbox"/> Base of skull |
| <input type="checkbox"/> Low back pain/stiffness | <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Sitting | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Pins and needles in arms/legs | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Bending | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Excess perspiration | | | |

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If so, please list:

Personal Information

Full Name _____ Nickname _____
 Address _____ City _____ State _____ Zip _____
 Home Phone () _____ Work Phone () _____ Occupation _____
 Sex M F Marital Status S M D W Age _____ Birthday ___/___/___ SS# _____
 How Did You Hear About Our Clinic? _____
 Name Of Person Responsible For Account _____ Method Of Payment _____
 Emergency Contact Name _____ Phone () _____

Insurance Information

Relationship to Insured: Self Spouse Child Other
 If insured is self, complete any information not listed above
 If insured is someone other than yourself, please complete all information below:
 Insurance Company: _____ Phone Number: _____
 Address : _____
 Insured's ID #: _____ Group Number: _____
 Insured's Birth Date : _____ Insured's Employer: _____

Family Health History

| | Self | Father | Mother | Spouse | Brother(s) | Sister(s) | Children |
|---------------------|---------|---------|---------|---------|------------|-----------|----------|
| | Age () | Age () | Age () | Age () | Age () | Age () | Age () |
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Back Pain | | | | | | | |
| Bursitis | | | | | | | |
| Cancer | | | | | | | |
| Diabetes | | | | | | | |
| Disc Problem | | | | | | | |
| Emphysema | | | | | | | |
| Epilepsy | | | | | | | |
| Headaches | | | | | | | |
| Heart Trouble | | | | | | | |
| High Blood Pressure | | | | | | | |
| Insomnia | | | | | | | |
| Kidney Trouble | | | | | | | |
| Migraines | | | | | | | |
| Nervousness | | | | | | | |
| Scoliosis | | | | | | | |
| Sinus Trouble | | | | | | | |
| Stomach Trouble | | | | | | | |
| Other | | | | | | | |

Informed Consent to Chiropractic Adjustments and Care

| | | |
|---|--|---|
| Doctor <input style="width: 40px; height: 30px;" type="text"/> Initials | Patient <input style="width: 40px; height: 30px;" type="text"/> Initials | I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed below during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment. |
| Doctor <input style="width: 40px; height: 30px;" type="text"/> Initials | Patient <input style="width: 40px; height: 30px;" type="text"/> Initials | I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-ray, on me by the doctor of chiropractic names below and/or in this clinic authorized by the doctor of chiropractic listed below. I have had an opportunity to discuss with the doctor of chiropractic names below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, physical therapy burns, rib injury, and strokes. Strokes are the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, as in my best interests. |
| Doctor <input style="width: 40px; height: 30px;" type="text"/> Initials | Patient <input style="width: 40px; height: 30px;" type="text"/> Initials | I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. |

To Be Completed By The Patient:

Print Patient
Name:

Date Signed

____/____/____

Patient Signature: _____

Doctors
Signature: _____