Date (MM/DD/YYYY) Have you consulted a chiropractor before? Yes No

Whom were you referred by? Previous Chiropractor:

Age Birth date (MM/DD/YYYY) Gender: Male Female

Last name First Middle

Address Apt #

City State Zip

Home phone Cell phone Work Phone

Your preferred method of contact?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address

Emergency Contact Emergency Contact Phone

Occupation

Employer Address

May we contact you at work?

Yes No

Primary Care Provider’s name

Insurance Carrier Policy #

Insured’s Last name First M.I.

Insured’s Employer Insured’s Employer phone

Insured’s Employer Address

City State Zip

|  |  |
| --- | --- |
| **Marital Status** | **Smoker Status** |
| * Single | * Never a smoker |
| * Married | * Former Smoker |
| * Divorced | * Current occasional smoker |
| * Widowed | * Current daily light smoker |
|  | * Current daily heavy smoker |

*Please describe your most problematic symptoms below. Use additional complaint boxes if necessary.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Primary Symptom/Complaint:** | | | | |
| Please provide a brief description of your symptoms: | | | | |
| My Injury is the result of: | | | | |
| * Work | * Auto | | | * Other |
| If other, please specify: | | | | |
| When did you first notice symptoms? | | | | |
| What have you done to alleviate your symptoms? | | | | |
| * Prescription medication | | * Over the counter drugs | * Homeopathic remedies | |
| * Physical therapy | | * Surgery | * Acupuncture | |
| * Ice | | * Massage | * Chiropractic | |
| * Heat | | * Other: | | |

What else should Welcome to Health know about your current condition?

Does your current condition interfere with (if yes, please detail):

Work or Career:

Recreational Activities:

Household responsibilities:

Personal Relationships:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Secondary Complaint:** | | | | |
| Please provide a brief description of your symptoms: | | | | |
| My Injury is the result of: | | | | |
| * Work | * Auto | | | * Other |
| If other, please specify: | | | | |
| When did you first notice symptoms? | | | | |
| What have you done to alleviate your symptoms? | | | | |
| * Prescription medication | | * Over the counter drugs | * Homeopathic remedies | |
| * Physical therapy | | * Surgery | * Acupuncture | |
| * Ice | | * Massage | * Chiropractic | |
| * Heat | | * Other: | | |

What else should Welcome to Health know about your current condition?

Does your current condition interfere with (if yes, please detail):

Work or Career:

Recreational Activities:

Household responsibilities:

Personal Relationships:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tertiary Complaint:** | | | | |
| Please provide a brief description of your symptoms: | | | | |
| My Injury is the result of: | | | | |
| * Work | * Auto | | | * Other |
| If other, please specify: | | | | |
| When did you first notice symptoms? | | | | |
| What have you done to alleviate your symptoms? | | | | |
| * Prescription medication | | * Over the counter drugs | * Homeopathic remedies | |
| * Physical therapy | | * Surgery | * Acupuncture | |
| * Ice | | * Massage | * Chiropractic | |
| * Heat | | * Other: | | |

What else should Welcome to Health know about your current condition?

Does your current condition interfere with (if yes, please detail):

Work or Career:

Recreational Activities:

Household responsibilities:

Personal Relationships:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Review of Systems: Please place a check mark if applicable** | | | | | | | | |
| System | Had | Have | System | Had | Have | System | Had | Have |
| **Muscoskeletal** |  |  | **Neurological** |  |  | **Cardiovascular** |  |  |
| Osteoporosis |  |  | Anxiety |  |  | High BP |  |  |
| Arthritis |  |  | Depression |  |  | Low BP |  |  |
| Scoliosis |  |  | Headache |  |  | High cholesterol |  |  |
| Neck pain |  |  | Dizziness |  |  | Poor circulation |  |  |
| Shoulder problems |  |  | Pins and Needles |  |  | Angina |  |  |
| Hip Disorder |  |  | Numbness |  |  | Excessive bruising |  |  |
| Knee Injuries |  |  |  |  |  |  |  |  |
| Foot-Ankle Pain |  |  | **Respiratory** |  |  | **Digestive** |  |  |
| Back Problems |  |  | Asthma |  |  | Anorexia/Bulimia |  |  |
| TMJ Issues |  |  | Apnea |  |  | Ulcer |  |  |
| Poor Posture |  |  | Emphysema |  |  | Food sensitivities |  |  |
| Elbow/Wrist pain |  |  | Shortness of breath |  |  | Heartburn |  |  |
|  |  |  | Hay Fever |  |  | Constipation |  |  |
| **Sensory** |  |  | Pneumonia |  |  | Diarrhea |  |  |
| Blurred vision |  |  |  |  |  |  |  |  |
| Ringing in ears |  |  | **Skin** |  |  | **Endocrine** |  |  |
| Hearing loss |  |  | Skin cancer |  |  | Thyroid issues |  |  |
| Chronic ear infections |  |  | Psoriasis |  |  | Frequent infection |  |  |
| Loss of smell |  |  | Eczema |  |  | Immune disorder |  |  |
| Loss of taste |  |  | Acne |  |  | Swollen glands |  |  |
|  |  |  | Hair loss |  |  | Low energy |  |  |
| **Genitourinary** |  |  | Rash |  |  | Hypoglycemia |  |  |
| Kidney Stones |  |  |  |  |  |  |  |  |
| Infertility |  |  | **Constitutional** |  |  | **Constitut. Cont.** |  |  |
| Bedwetting |  |  | Fainting |  |  | Poor appetite |  |  |
| Prostate issues |  |  | Low libido |  |  | weakness |  |  |
| Erectile Dysfunction |  |  | Sudden weight gain/loss (circle) |  |  |  |  |  |
| PMS symptoms |  |  | Fatigue |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

Other:

**Past, Personal, and Family Histories**

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous History** | | | | | | | | |
| **Illnesses** | Have | Had | **Treatments** | Past | Current | | **Operations**:  Surgical interventions which may or may not have required hospitalization | Check mark indicates Yes |
| AIDS |  |  | Acupuncture |  |  | |
| Alcoholism |  |  | Antibiotics |  |  | |
| Allergies |  |  | Birth control pills |  |  | |  |
| Arteriosclerosis |  |  | Blood Transfusions |  |  | |  |
| Cancer |  |  | Chemotherapy |  |  | | Appendix Removal |  |
| Chicken pox |  |  | Chiropractic Care |  |  | | Bypass surgery |  |
| Diabetes |  |  | Dialysis |  |  | | Cancer |  |
| Epilepsy |  |  | Herbs |  |  | | Cosmetic surgery |  |
| Glaucoma |  |  | Homeotherapy |  |  | | Elective Surgery: |  |
| Goiter |  |  | Hormone replacement |  |  | | Eye Surgery |  |
| Gout |  |  | Inhaler |  |  | | Hysterectomy |  |
| Heart Disease |  |  | Massage Therapy |  |  | | Pacemaker |  |
| Hepatitis |  |  | Physical Therapy |  |  | | Spine: |  |
| HIV Positive |  |  |  |  |  | | Tonsillectomy |  |
| Malaria |  |  | **Allergies:** | Yes | No | | Vasectomy |  |
| Measles |  |  | Are you allergic to any medications? |  |  | | Other: |  |
| Mumps |  |  |  |  |  | |  |  |
| Multiple Sclerosis |  |  | Please List | medications |  | | **Injuries:** In the past, have you |  |
| Polio |  |  |  |  |  | | Had a fractured/broken bone |  |
| Rheumatic Fever |  |  |  |  |  | | Had a spine or nerve disorder |  |
| Scarlet Fever |  |  |  |  |  | | Been knocked unconscious |  |
| Sexually Transmitted Infections |  |  |  |  |  | | Been injured in a car accident |  |
| Stroke |  |  | Please list below all prescriptions. Over the counter, natural supplements, enzymes, vitamins, and minerals: | | | | Used a crutch or other support |  |
| Tuberculosis |  |  | Used neck or back bracing |  |
| Typhoid Fever |  |  | Received a tattoo |  |
| Ulcer |  |  | Had a body piercing |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |
|  |  |  |  |  | |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family History:**  (Some health issues are hereditary. Tell Welcome to Health of your immediate family members.) | | | | | | | |
| Relative | Age  (if living) | State of health | | Illnesses | Age  (at death) | Cause of Death | |
|  |  | Good | Poor |  |  | Natural | Illness |
| Mother |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |
| Sister 1 |  |  |  |  |  |  |  |
| Sister 2 |  |  |  |  |  |  |  |
| Brother 1 |  |  |  |  |  |  |  |
| Brother 2 |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Are there any other hereditary health issues that you know about?

|  |  |  |  |
| --- | --- | --- | --- |
| **Social History:**  (Tell Welcome to Health about your health habits and stress levels.) | | | |
| **Substance/Practice** | **Daily** | **Weekly** | **How much?** |
| Alcohol |  |  |  |
| Coffee |  |  |  |
| Tobacco |  |  |  |
| Exercising |  |  |  |
| Pain relievers |  |  |  |
| Soft drinks |  |  |  |
| Water intake |  |  |  |
| Prayer/Meditation |  |  |  |
| Job pressure/stress |  |  |  |
| Financial peace |  |  |  |
| Vaccinations |  |  |  |
| Mercury fillings |  |  |  |
| Recreational drugs |  |  |  |

What are your hobbies?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activities of Daily Living**  **(**How does this condition currently interfere with your life and ability to function? Please check in the appropriate box.) | | | | | | | | | |
| **Activity** | No effect | Mild effect | Mod. effect | Severe effect | **Activity** | No effect | Mild effect | Mod. effect | Severe effect |
| Bending over |  |  |  |  | Lifting objects |  |  |  |  |
| Caring for family |  |  |  |  | Looking over shoulder |  |  |  |  |
| Climbing stairs |  |  |  |  | Love life |  |  |  |  |
| Concentrating |  |  |  |  | Lying down |  |  |  |  |
| Driving a car |  |  |  |  | Reaching overhead |  |  |  |  |
| Dressing self |  |  |  |  | Rising out of chair |  |  |  |  |
| Eating |  |  |  |  | Showering or bathing |  |  |  |  |
| Exercising |  |  |  |  | Standing |  |  |  |  |
| Falling asleep |  |  |  |  | Staying asleep |  |  |  |  |
| Getting in/out of car |  |  |  |  | Using a computer |  |  |  |  |
| Grocery shopping |  |  |  |  | Walking |  |  |  |  |
| Household chores |  |  |  |  | Yard work |  |  |  |  |

What is the major stressor in your life?

How much sleep do you average per night?

What is the type and approximate age of your mattress and pillow?

What is your preferred sleeping position?

Describe your typical eating habits:

What would be the most significant thing that you could do to improve your health?

In addition to the main reason for your visit today, what additional health goals do you have?

**Acknowledgements:**

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and **initial** our agreement.

I instruct the chiropractor to deliver the care that, in his or her judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidences and is designated to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

I realize that an x-ray examination may be hazardous to an unborn child and I certify that, to the best of my knowledge, I am not pregnant. Date of my last menstrual period:

I grant permission to be called or confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of covered or non-covered services I receive.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or nature of my health concern.

Self/Parent/Guardian signature Date (MM/DD/YYYY)

**PRESCRIPTION & SUPPLEMENT LIST**

*Please list your ACTIVE medications and supplements (not past medications).*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Strength**  (i.e. 10mg) | **Dose**  (i.e. 2 tablets) | **Frequency**  (i.e. 2x/day or every # hours) | **Method**  (i.e. oral, topical) | **Date Started** |
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**DRUG ALLERGY LIST**

|  |  |  |
| --- | --- | --- |
| **Medication (or family of drugs)** | **Onset Date** | **Reaction**  (i.e. rash, vomiting, difficulty breathing,dizziness) |
|  |  |  |
|  |  |  |
|  |  |  |